# THE CODIFICATION OF THE CULTURAL HEALTH BELIEF MODEL AMONG THE SOUTHWESTERN OJIBWE

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Dedication

To my parents.

## ABSTRACT

The Cultural Specific Approach to Health Model codifies an *a priori* approach to reconstruction of the health belief theory and significantly impacts medication experiences. The objective was to codify the Cultural Specific Approach to Health Model as an *a priori* construct to establish and explain a responsive framework of healthcare modeling demonstrated by the relationship of the Anishinaabe peoples' Cultural Specific Approach construct of *Bimaadiziwin.* Propositions are: (1) why are phenological or traditional practices important to understand with the Cultural Specific Approach; (2) why is the relationship of spiritual and healing practices significant to the contribution of the Cultural Specific Approach; (3) what role does happiness discriminate in the psychosocial relationship to Cultural Specific Approach; and lastly, (4) what best defines professional cultural competency for practitioners to enhance patient's perceptions of health and reported outcomes? The nomothetic study included eight providers, twenty-six healthcare administrators and 455 self-identified Ojibwe adults with a diagnoses of substance use disorder, and other chronic illnesses, living on five Ojibwe rural reservations designated as medically underserved areas in the Midwest region of the United States between 2014 and 2018. Two areas were examined within three case study units: 1) the methodological initiation; and, 2) a novel pharmaceutical practice care approach based on the Cultural Specific Approach to Health Model.

The results of the study showed positive changes in behaviors within a population that demonstrated the highest prevalence of substance use disorder and highlighted the integrated role of the pharmacists' practice to combat opioid addiction.

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AI/AN—American Indian Alaskan Native, indigenous to the US

AIGC—American Indian Graduate Center

BIA—Bureau of Indian Affairs

CDC—Centers for Disease Control and Prevention

CF—Chippewa Federation

CHB—Cultural Health Belief

CHSDA—Contract Health Service Delivery Area

CHW—Community Health Workers

CMS—Centers for Medicare and Medicaid Services

DOJ—Department of Justice

EIM—Ethnographic Inquiry Model

HBM—Health Belief Model (any extension of the HB model thereof)

HHS—U. S. Department of Health and Human Services

IHS—Indian Health Service

GLATHB—Great Lakes Area Tribal Health Board

GLITEC—Great Lakes Inter-Tribal Epidemiology Center

MAT—Medication Assisted Therapy, also phrased as MAR, Medication Assisted Recovery

MAST—Midwest Area Sovereign Tribes

MCT—Minnesota Chippewa Tribes

NIEA—National Indian Education Association

NCAI—National Congress of American Indians

NIHB—National Indian Health Board

SAMHSA-- Substance Abuse and Mental Health Services Administration

TEC—Tribal Epidemiological Centers

T-MTM—Tribally-focused Medication Therapy Management

# CHAPTER 1

# INTRODUCTION

## 1.1 Overview

The Cultural Specific Approach to Health model is the author's original term to codify the unique ways of thinking and behavior; assert *a priori* descriptive practices that characterize a community of people through its historical and contemporary environments, and build authentic, strength-based guiding principles of that community in developing a sustainable model of collaborative health practice. The Cultural Specific Approach to Health model for this study embodies references to philosophies and practices of tribal people in American Indian communities; yet, there are far fewer studies where the tribal cultural and spiritual perspectives are considered meaningful within patient - centered outcomes research.

The Cultural Specific Approach to Health model reconstructs the normative psychosocial determinant of health belief theory to place it first before all other constructs investigated and highlight the essential theory of a culturally specific approach to health. Despite the numerous health care initiatives designed for patient care and provision of health care services, cultural specificity was omitted in the primary step that improves the methods that contribute to all properties of quality outcomes in healthcare. This nomothetic study attempts to codify the cultural specific approach to health care modeling that significantly impacts medication experiences, highlights perceptions of belief toward medicine, and improves outcomes in a community setting. Specifically, the analysis aims

to demonstrate the remarkable successes of three case studies based on the integration of the *a priori* Cultural Specific Approach to Health model. While acknowledging that standard accepted practices in patients' health care originate from a medical perspective, there were many cases that supported a combination of the Cultural Specific Approach model and pharmaceutical care concepts focused on personal psychosocial behaviors rooted in the humanity of life and death. Pharmaceutical care is patient-centered practice where the practitioner is responsible for the patient's drug-related needs.

The aim of pharmaceutical care practice is for the purpose of positive patient outcomes. Thus, theory-integrated pharmaceutical care practices influence a deeper understanding of existing health belief protocols for both the patient and pharmacist as the provider. It provokes a positive, welcoming effect of achievable healthcare goals for the patient and care provider, in this case, combatting diabetes and opioid addiction. Overall, this study presents a valuable opportunity to further expound a pharmaceutical care model generalizable for any community of people – with the principle advancement – codifying the *a priori* position of a Cultural Specific Approach model. The Cultural Specific Approach model designates the patient's first preference in health thinking and belief relative to descriptive characteristics or discerning predictors addressing health care and adherence to drug therapy.

Regardless of the diversity of publications on American Indian spirituality and indigenous health belief models, literature is scarce on an authentic, tribally-specific understanding of healthcare and its singular importance to the tribal nations it represents —none more central to the Anishinaabe people of Great Lakes region of the United

States. The specificity of a social health foundation determines a keen understanding of the qualitative measures that support the subsequent appropriate theory and quantifiable research designs that can transform healthcare outcomes and fully inform tribal principals.

Considering the meteoric rise in chronic illness, unintended corollaries of mortality and morbidities, and the opioid addiction crises that daily affect populations on a global scale, few critics would challenge the motivation to explore central avenues to improve the state of health today. Even so, there are few references to healthcare options for American Indians who predominantly have the highest or near highest prevalence for chronic disease (i.e., diabetes mellitus type II, cardiac, cancer, and stroke) that are grounded on their characteristics (Barnes, Adams, and Powell-Griner, 2010). According to an extensive literature search through 2019, no models exist that codify the existence and value of an Anishinaabe health and wellness theory. This dissertation codifies the Cultural Specific Approach theory and lends explanatory significance of the Cultural Specific Approach model for the U.S. Southwestern Anishinaabe tribes. The same approach can be generalized to explore renewed outcomes and updated evaluation of healthcare value systems from the data of many communities of people with the appropriate intra-participatory partnerships.

Throughout this dissertation study, the term Anishinaabe(g) is the preferred classification even though Ojibwe is widely recognized and used interchangeably. This designation is due to personal preference of earlier familial generations who were from northern areas of Canada and were settled in the southwestern area of the Great Lakes

region (Hickerson, 1962). Hence, the term ‘southwestern’ also signifies a generational preference for describing the influence of familial tribal migration originating from the Canadian region; but, subsequently halted with forced homesteading within the reservation boundaries in northern Wisconsin (Quaderer-Johnson, personal communication, 1969).

Schwartz, an ethnologist and cross-cultural researcher (1992), discusses the impact of fundamental human values and Gouveia (2014) suggests that values function as standards that guide thought and action. Despite the many studies that point to numerative indices of characteristics that define healthcare and conceivably estimate the earned value of patient-centered healthcare (Adams and Strother-Adams, 2001; Anderson, 2018; Rokeach, 1973), outcomes research is still misinterpreted within the context of American Indian healthcare. Understanding the necessity of a culturally specific approach model for the Anishinaabe nations is paramount to utilize interactive measures of tribal data and tribal community engagement that regularly inform tribal leadership and federal responsibility on how to maneuver through the scarcity of resources and yet provide the obligations bound under the fiduciary trust responsibility of the U.S. government. However, when results of research are evaluated on the basis of non-Native values and terminology, which reflect principles of mainstream or Westernized American culture (Doran and Littrell, 2012), and no ethnographic research or biostatistician undertakes the time to reevaluate analytical methods and survey inquiry measures, valuable opportunities for future research are limited. Hence, qualitative research endpoints that should build out collaborative therapeutic practice models for

American Indian health are less representative of the community of people it epitomizes. Value, as a component of healthcare, is lessened (Tuulik, Õunapuu, Kuimet, and Titov, 2016). Challenging questions about cultural specificity and policies are often brought forth in tribal forums and those comments posed by health care administrators and tribal leadership leads back to principles of validation (Tuulik et al., 2016; Rokeach, 1973). How do we measure health components and ultimately pay for that reform measure if we do not know the value of that service? Where do we start the change in our approach and what measures are essential when working with communities of people especially if we are mandated to transform healthcare policy and procedures? Those questions are best answered based upon detailed knowledge and explanatory measures of the cultural specific health belief approach from the start.

Outcomes research is fortuitous for Native peoples when it commences with the appropriate Cultural Specific Approach model. Outcomes research, for example, has opened up numerous opportunities for exploration and explanation of genetic variances in medication-assisted therapy, especially in chronic diseases, such as diabetes and the genetic science of the rapidly evolving, individualized Precision Medicine initiatives (Feero, Wicklund, and Veenstra, 2018). The time for informed, reasoned approaches to understanding behavioral changes in response to pharmaceutical drug therapy is now, and the Cultural Specific Approach model proposed here can provide the transition to bring patient perspectives to the forefront and not as an afterthought.

In many instances, governing policies in tribal health care reflect data-driven measurements not representative of the regional sample. Although Anishinaabe people

are becoming more cognizant of the mainstream policies that affect their health status as an indigenous population residing in the Great Lakes region, their tribal ideological principles are less appropriately defined and normed for their communities. Instead, the sample dependency reflects standards of practice variables that emanate from a far different region and not sampled from the area from which the population resides. These challenges create unreliable measures of value and policies that sometimes, imperceptible to the sovereign nations they are purported to represent, perpetuate perspectives on healthcare that remain exceedingly less transparent. Moreover, when selected negotiations occur during the sovereign tribal-federal convening, the tribal health leadership present tribal and community case issues that declare their political agenda to pursue changes within the federal government entities, but vastly fall unheeded. Their collective tribal leadership voices reflect a historical conflict due to the dreadful trauma experienced through the early years of strained statehood relationships between the American Indians citizenry and U. S. government.

Even as knowledge of tribal affairs increases and subsequent dependence on affordable health insurance is made available through the Affordable Care Act of 2010, the rise of higher education in tribal students, the Self-Determination Act of 1975, the outcomes of all these research priorities still reflect many gaps in understanding tribal health policies. Initially, observations reveal that the specific health belief theory was omitted in health initiatives and healthcare program planning before the tribal government leadership. Subsequently, the outcomes demonstrate even more problems as described in the rejection of neighborhood clinics, the prevalence of clinic ‘no- show’

visits, misaligned standard policies of healthcare administration, perceived adversity in a clinical approach (no pharmacist-patient communication) to medication management, and complaints about cultural congruency in relation to providers and staff workforce. These healthcare disruptions are current examples of escalating tribal and federal-state demands to fix healthcare, and that burden corresponds to the purpose of why the Cultural Specific Approach model is beneficial.

Implicit in this study is the philosophy that a specific approach to a health model must first be addressed. Starting with a community approach, tribal community members must be able to partner in health-design strategies and therapeutic reasonings relevant to their community-culture, beliefs, traditions, and customs—not individualized--but on a holistic scale that defines the characteristics of that specific community of people. What defines the health belief of a particular community? What is the history of that community? For example, recent clinical data from Ojibwe reservation clinics reveal diabetes as the leading cause of limb amputation, stroke, and blindness (Barnes, Adams, and Powell-Griner, 2010). For researchers and practitioners alike, engagement with the people should be the first intent in understanding the cultural specifics tied to health belief models that can effectively change patient behaviors and compliance with medication therapy.

As patients, merely acknowledging the prevalence of existing diabetic disease status ranks exceedingly high, and ineffectively looking past the underlying cultural orientation ceases to address valuable cultural congruency. Cultural congruency reduces the overarching problem of providers not being able to communicate with the

tribal people, in their way of life, ways of thinking, and on their terms (Street, O'Malley, Cooper, and Haidet, 2008). The consequence of the non-communicative flow of information (Kutob, Bormanis, Crago, Senf, Gordon, and Shisslak, 2013) and lost engagement within a tribal health environment assuredly contributes to severe adverse health conditions: individual's loss of limb, stroke, and blindness without an intervention such as a cultural health belief connection.

As survey respondents, tribal residents infrequently participate in survey questionnaires about how they live their lives and the values necessary to them, the scalable inquiry methods vary in understanding the significance of the personal values they place on their cultural life and the decision-making process associated with adherence and intent to self-preserve. The critical questions regarding how much variance is relevant to compliant therapy may be answered according to understanding the underlying Cultural Specific Approach Model effect and those studies may influence future changes in adjuvant therapies, such as pharmaceutical interventional options in opioid palliative research (Ghosh and Berger, 2014). These questions may be as simple as: What do I need to know as a community pharmacist or provider in the community where I practice? What defines my role as a pharmacist provider in this community I serve? How have I contributed to the knowledge of medication safety in sharing with patients in my community? Does the community understand my role as a primary healthcare provider in their healthcare? The relevant hypotheses require recommending and developing a new instrument to assess a cultural congruency relationship scale of measurement based on the professional requirements for cultural competency already in

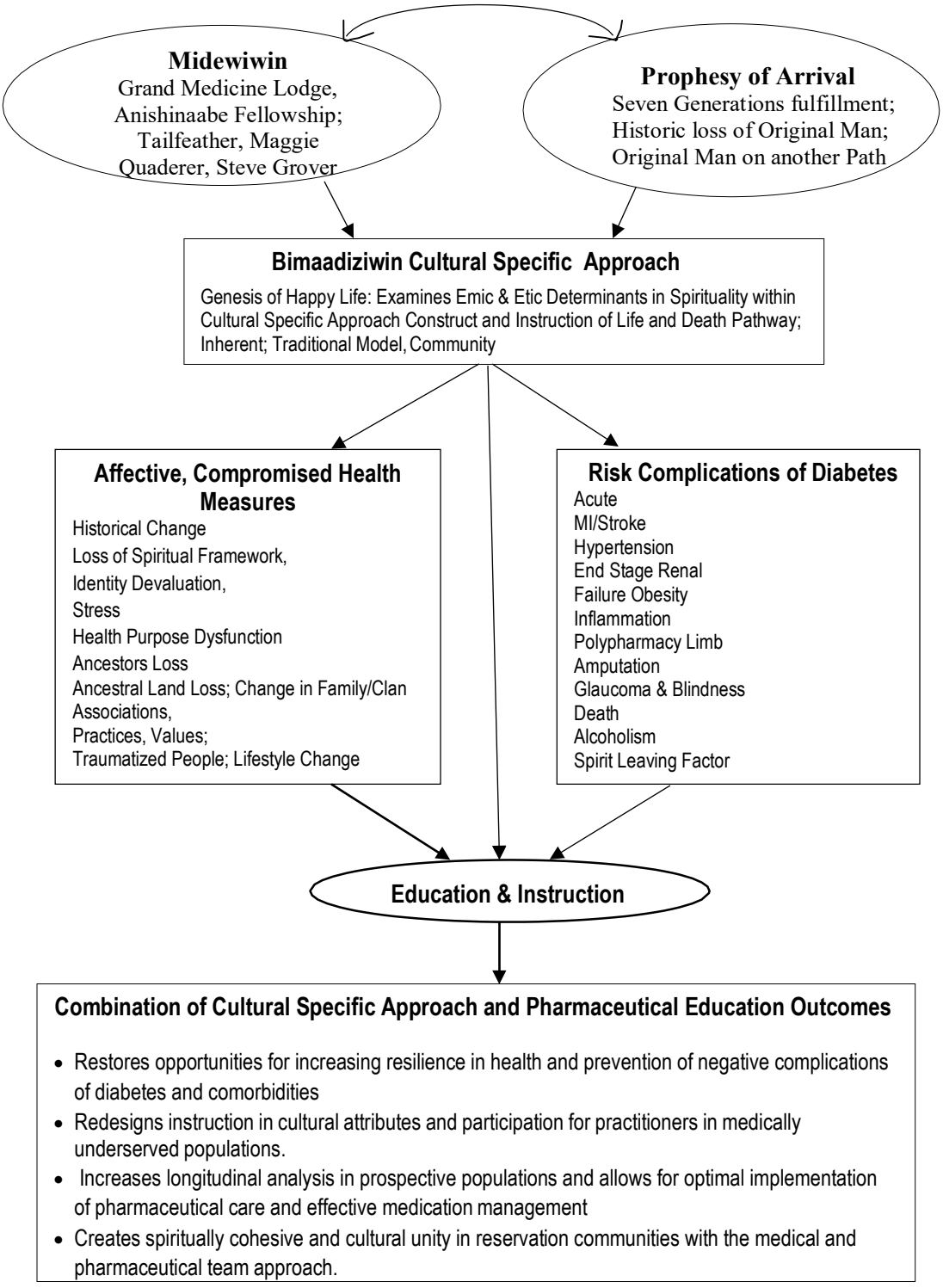
practice curriculum and professional assessment (Brach and Fraserirector, 2000; DeVellis, 2012). Thus, a schematic was developed to portray the utility of the Anishinaabe Cultural Specific Approach Model as essential for understanding the cultural dialogue and relationship of native domain patient-centered health care (Figure 1). Additionally, revitalization of the cultural specific approach seeks to restore important health determinants of tribal people beyond the modest recognition of simple cultural phrases that were vaguely indicative of larger thematic constructs.

The Cultural Specific Approach Model and the Ethnographic Inquiry Model described in Chapter Two and its subsequent methodology of survey instruction have the potential to radically alter how we understand the sociological and societal culture and health belief that represents the tribal people. Moreover, most efficiently teaching practitioners about a uniquely "tribally-focused medication management therapy services" (T-MTMs) and motivating a new stream of cultural, therapeutic praxis are discussed.

Probably at no other time in history has this proposed initiative been capable of sustaining its aim to identify a specific tribal cultural specific approach as a unique health construct. Thus, while the opportunities to present cultural health through the lens of the American Indian is at a political precipice, and the momentum to Cultural Specific Approach modeling are the main topics of this dissertation, it is also a proposed next step in aligning critical community-based quantitative methods in supportive patient-centered health care. Accordingly, the Cultural Specific Approach model demonstrates within the heart of every community of people that there is a salient theme that represents their

reason for living, a personal identity so distinctly associated with their cultural and spiritual belief. This study acknowledges the promising opportunities that exist when the research models focus on utilizing the pharmacist as provider and patient engagement from the basic evaluation of health triage to recovery and aftercare. Supportive services and medical professions, mainly pharmaceutical care practice, must meet a societal continuum of care. Hence, from the pharmacist-as-provider viewpoint, understanding the connections of the patient within their community and developing a healthcare plan that reflects meaningful participation from the patient community presents a better environment for wellness (Consuelo, Mapes, Jerome, Villalta-Gil, Pulley, and Harris. 2019; Cipolle, Strand, and Morley, 2012). Figure 1 displays this meaningful connection as a therapeutic relationship, called the Cultural Specific Approach to Health model between the history of the community, its memberships' concerns and a transformative plan to address education and productive outcomes within a pharmacy practice philosophy. For example, Figure 1 displays two sections of chronic conditions (*Affective, Compromised Health Measures and Risk Complications of Diabetes)* and while these are chronic and acute conditions experienced by the patient, the pharmacist can develop a therapeutic platform in which to guide the patient to recovery and at the same time, utilize educational and instructional procedures to ensure the continuum of care is optimally maintained. The pharmacist provider can better address the dynamic changes in the patients' care plan and support other issues as they arise knowing there is a course of action that reflects their standards of practice.

Figure 1. Cultural Specific Approach to Health Model with Bimaadiziwin



Therefore, the definition of culture here in its sociological application is “the ways of thinking, the ways of acting, and the material objects that together shape a people's way of life” (Macionis and Gerber, 2011; *see definition of culture for more explanation in Definition of Terms, Section 1.6*). Respective to Bimaadiziwin, the Cultural Specific Approach of the Anishinaabe culture may be defined as: The ways of *the People*, blessed by the spiritual gifts of love, wisdom, respect, and honor, and known by traditional practices with family guided by the Creator. Thus, it may be unclear whether differences in the reservation population profile between age groups seen in the general population or Anishinaabe who left the reservation and are assimilated into Western societies will be similar or different based upon their cultural ways of life, thinking, and predictive behaviors. The Cultural Specific Approach model reconstructs these normative and psychosocial determinants of health belief theory to place the Cultural Specific Approach model first before all other constructs investigated. The Cultural Specific Approach model examined via ethnographic inquiry can seamlessly intersect cultural competency components to improve inequities and preserve cultural understanding of diverse tribal populations particularly for rural Anishinaabe reservations.

### 1.2 Objective

The objective of this study is to codify the Cultural Specific Approach model as an *a priori* construct to establish a new framework of healthcare modeling through the relationship of the Anishinaabe peoples’ cultural specific construct of *Bimaadiziwin.*

## 1.3 Purpose of the Study

The purpose of this study is to distinguish the prominence of the Cultural Specific Approach model as the principal feature of the Health Belief Model and apply its precepts in a participatory manner that guides professionals to make informed decisions for treatment based upon expert cultural collaboration and cultural competency.

## 1.4 Significance of the Study

Recently, with the reauthorization of the Indian Health Service Health Improvement Act (Ross, Garfield, Brown, and Raghavan, 2015), tribal leaders present evidence to the federal Indian Health Service regional directors and national health boards on how healthcare legislation and policy efforts are utilized within their rural communities. However, the tribal presenters consistently emphasize the need and request for improvements with communication from providers and recognition for their health beliefs. This request for improved communication and respect for their health beliefs is noteworthy to address since census projections for minority Americans are expected to rise by more than 40 percent by 2045 (Vespa, Armstrong and Medina, 2018; U.S. Bureau of the Census, 2017). Consequently, and as a response to correcting the gap in relationship care, this unique study fills the space between understanding a culturally specific approach and meaningful communication of the provider to the patient. It demonstrates authenticity beyond the cultural competency level and asserts the vital construct of personal and significant identity reaffirmation of a long-neglected group of Original Inhabitants of North America. This study presents the first step in restoring the premise that patient-centeredness is really about what is best for the patient and quality of life beyond an extraneous exercise

in technical policy requirements or complementary competency verbosity.

There comes a time where there have been so many health interventions and strategies proposed to minority populations like the American Indian people that the end results are a blended redundancy of programs that do not address or solve the issues. The same contextual conversations have not changed about chronic disease and substance addiction that detrimentally affects the quality of life for American Indian people and that perception must invoke change. Furthermore, American Indian people recognize the immediate need for a different approach and this is where the collaboration between university researchers, practice clinicians, and community members is so important. Collaborative practice provides valuable opportunities that shift to healthcare researchers to analyze and develop appropriate survey instruments. Most researchers are unaware what the comments truly mean from American Indian respondents because it is outside their conceptual worldview or ideological view unless they are taught a different approach to healthcare assessment (Minnesota Department of Health, 2012). Hence, the Cultural Specific Approach model supports the first step of this corrective action plan.

The Cultural Specific Approach examines the issues in health care adherence, medication compliance, and the resolute awareness to affect health behaviors that are demonstrated in the conceptualization of prioritizing the Bimaadiziwin Cultural Specific Approach and this ordering best embodies the domain of the Anishinaabe culture. The study introduces the ethnographic survey that highlights patient-centered care.

## 1.5 Definition of Terms

The following is a list of terms that are used in the proposed study:

Anishinaabe(g): Spirit Person of the Algonquian-linguistic speaking Ojibwemowin, or sometimes referred as Anishinaabemowin. (Anishinaabe as a singular noun, Anishinaabeg is plural form). The following quote underscored European misconception of the identity of the original inhabitants of the North American continent. "Even after they came to be considered human after all, and not without fierce and prolonged debate among church and legal scholars, Indigenous peoples of Turtle Island were defined according to Old World European conceptualizations" (Kelly, 2003, pg. 9).

Bimaadiziwin: Meaning "life," or euphemistically as the "good life" (*mino-bimaadiziwin)* pathway of life's journey as an Anishinaabe. It is a life of choices, turns, challenge, and opportunities. It is the explanation of life and how to live this life journey on Aki, earth.

Ceremony: About celebratory or recognition of a momentous time set aside for remembrance of an event, gathering, or ritual significant for tribal members, usually as a religious rite. Ceremonies are highly significant to Indian religious beliefs and incorporated as a significant time set aside in the affirmed ways of Indian people.

Culture: Culture consists of integrated patterns, explicit and implicit, of human behavior that include the common or ethnospecific language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (Center for Substance Abuse Treatment, 2014). Culture consists of patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols, constituting the

distinctive achievements of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, and on the other as conditioning elements of further action (Kroeber and Kluckholm, 1952). Culture in this study is defined by the author as the ways of The People, blessed by the spiritual gifts of love, wisdom, respect, and honor, and known by traditional practices with family guided by the Creator.

Cultural Competency: Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs to be accessible by consumers and their communities (U.S. Department of Health and Human Services, 2001).

Cultural Respect: The concept of cultural respect has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients (*Clear Communication,* n.d., para. 1).

Cultural Specific Approach: A theory modification utilizing internal values and core beliefs central to the relationship of the patients' perception of health status to promote understanding how and why the *a priori* cultural specific approach model changes the behavioral health outcomes of patients in response to managing health belief models.

Indian Medicine: Medicines that are handed down through individuals within families and acquired forms of healing instruction, usually withheld until special healing is

necessitated. Not all medicines are regarded as Indian medicine, mushkiki; and, most conventional forms of plant (location, formulation, and dose) knowledge have been lost with the passing of the last generation of old-time healers born as in the early half of the 21st century.

Medicine People: A term used to describe traditional healers who are widely respected for their knowledge of healing powers and influence to receive help from the Creator to use animal, organic (rock and artifact), plant-type medicinal properties. Medicine people, widely esteemed, lived humbly and politically apart and garnered the highest favor by Anishinaabe and other tribal nations. Medicine People accumulate much knowledge about the environment such as the life force held within plant life. Plants, to the Anishinaabe, are held in wide respect as a spiritual being, and a gift from the Creator for healing, life needs like shelter and food, and aesthetic beauty. The other essential healing artifacts are animal beings. To the Anishinaabe, the animal has the same right to life that man has. It is necessary to use the animal for the sustenance of man, and the animal is sacrificed regretfully for this purpose. However, the animal knows its calling and observes its function. Many ceremonies acknowledge the gift of the animal-being through select teachings in the life of an Anishinaabe.

Midewid: A person initiated in the Midewiwin Grand Medicine Lodge, having a spiritual connection as a Mide Manidoog.

Midewiwin: Healing practices within the Midewiwin Grand Medicine Lodge is locally known throughout Minnesota, Wisconsin, and Michigan Anishinaabe tribes. It is a formal

ritualized spiritual life practice that emphasizes the gifts of creation and ways of life from the Creator, *chi gichi manido.*

Manidoog**: S**pirit-beings who help mankind.

Mushkiki: Medicine, usually in plant form, for special healing.

Reservation: Sections or sectors of land set aside as federal status land provided to Anishinaabe headmen, or clan chiefs in response to land that was taken by force when states were achieving statehood. This time in the history of the American Indian was a devastating era that forever changed the lives of American Indian people. Between the years of 1830 – 1838, ethnologist George Catlin (1841) describes his observations with the clash of the "civilized world" and the ill-treatment of the Indian by European- Americans, who not understanding the customs that preserve health and daily function sought to change their world and mostly succeeded. Through the removal of the American Indian in Minnesota and Wisconsin, Catlin's narrative preserved the evidence that underscored the tribulations tribes consequently faced in famine, the inevitable loss of family, trust, and indigenous cultural practices.

# CHAPTER 2.

# BACKGROUND OF THE STUDY

## 2.1 General Problem

The general problem area of concern to this dissertation study reveals the omission of an appropriate health belief model for American Indian tribal citizenry. The dominant health belief models historically have not ever represented the accurate logic or sensitivity of how American Indians view their health status. For most American Indian residents who are living on federally-designated reservations, the notion of health equity is by far, unachievable, unless their cultural beliefs and values can be a part of and represent their patient care experience. The Cultural Specific Approach is defined as: A theory modification utilizing internal values and core beliefs central to the relationship of the patients' perception of health status to promote understanding about how and why the *a priori* cultural specific approach model changes the behavioral health outcomes of patients in response to managing health belief models.

Throughout the study, the salient questions of personal health perspectives and cultural values are reflexively posed: How might a culturally specific approach transform or restore trust in health care on reservations where socioeconomic determinants fall exceedingly below mainstream scales? How can reservation residents that live in medically underserved areas where health access is limited to none and health

literacy remains at an overall low level achieve health competency?

For residents living on reservations, there have been many supportive programs to remedy poverty-related issues and many aid technical prevention programs; but, research supporting cultural collaborations between providers and patients are distinctly few. These underlying themes of trust relationships between tribal American Indian patients and practitioners have not ever been studied in research outcomes yet; these valuable outcomes are critically important to restoring fundamental communicative working relationships with indigenous populations in remote environments like the federal reservations. With this in mind, the direct inclusion of the Cultural Specific Approach model as a pivotal, first-line approach among other tribal nations offers health practitioners who serve American Indian patients a better understanding of how best to communicate with tribal or indigenous community partners. Thus, the Cultural Specific Approach contributes significantly to improving health promotion among community participants, ensuring trust relationships, and improve health inequities.

## 2.2 Specific Problem

Healthcare models omit the theory of cultural specificity to health beliefs as a first step process in building patient-provider relationships and for improving therapeutic practice. For the American Indians, the original inhabitants of the northern continent, who retained their cultural ways of thinking, and specifically, the Anishinaabeg people, though very skilled at healing, practiced their medicinal traditions in the manner that was most reflective of their life's philosophy (Blessing, 1955). The important measure of understanding how healthcare evolved is through a balance of communication between the

patient-client and the provider, an integration of behaviors that promotes a healing environment. This environment is recognizable to the patient and a trust relationship develops. While there are many factors that increase communication and support trust within healthcare, the early communication and recognition phases are crucial when first meeting with patients. Below are two comments that were made to the author as the discussion of tribal healthcare and research initiated after a tribal health conference in 2016.

> *The main problem is Native American healthcare is not able to be represented by the vocabulary used by researchers because it is not personal enough to tribal patients. None of our research actually reaches natives. They don't know anything about the research that takes place in universities. You see how they react whenever we mention what white people say about us. They will excuse themselves mentally from the situation because it does not fit them."*
>
> ~ Anishinaabe reservation clinic pharmacy technician observation, personal communication, October 2, 2016.
>
> "*I can't quite put my finger on it. When I am at a ceremony, my head is clear, and I know what I am doing. But when you ask me to look at a journal article that you say describes me, I am more confused. I don't see myself in your world or your works."*
>
> ~ Anishinaabe business and health technology major college student, personal communication, September 15, 2016.

Most models of health belief systems are presented in the manner most befitting of Anglo American (Western) mainstream society (Adams and Strother-Adams, 2001; Doran and Littrell, 2012; Wan et al., 2007;) and are not at all representative of an authentic Anishinaabe manner of thinking (Brave Heart and DeBruyn, 1998; Catlin, 1841; Deloria, 1992; Duran and Duran, 1995; Duran, 2006;). Buffalohead (1993) and Churchill (2004)

emphasize that Westernized ideology is counterintuitive for getting individuals to respond, and even less effective to get them to change behaviors (Newcomb, 2013).

Historically, communal health instructions and medicinal knowledge among tribes (Benton-Benai, 1979; Vennum, 1982) were characteristically passed through oral tradition (Vecsey and Vennum, 1990; Warren, 1984; Whorf and Carroll, 1964). While acknowledging all indigenous tribes possessed their own cultural ways (St. Germaine, 2014), they were not acknowledged after colonization. Additionally, since the expansion of westernized ideology (Shkilnyk and Shkilnyk, 1985; Smith, 1973), the worth of health beliefs and how native people expressed their thinking generally have been neglected, or lawfully banned (Ross, 1992; Schoolcraft, 1851; Schenck, 1997; Skinner, 1914; Vecsey, 1983).

The significance of a culturally-informed health care system ensures the continuum of a comprehensive framework for health systems remains beneficial. For tribes today, understanding the tangible impact of socioeconomic factors that create daily barriers to parity in health collectively stem from a lack of health care insurance; affordable access to quality health care; and language differences – both in health literacy and health numeracy. Tribal interpretations of illness constructs; adverse cultural history with Western medicine, and health systems that are not well understood all contribute to lower health literacy. Lack of transportation to appointments and follow up care; lack of child care assistance to attend appointments, and lack of health providers from the community who are familiar with the essential communal services contribute to barriers for many clients seeking health services (Minnesota Department of Health, 2012). The *a priori* Cultural Specific Approach model serves best when every member of the health care system, patients, and their families, and the greater tribal community is informed, encouraged, and prepared to work collaboratively.

## 2.3 Ethnographic Inquiry Model

Moreover, this present qualitative study explains cultural iterations of the tribal people's desire for their health care, which in itself is so incredibly significant and overlooked without the use of suitable ethnographic inquiry methods. The Ethnographic Inquiry Model (EIM) is an iterative, mixed methods system of questioning that best defines the typology of the community of people of interest and normalizes the patterns of health beliefs, traditions, and practices as an *a priori* standard; thus, complementingthe Cultural Specific Approach. These methods of inquiry adapt the same questions; but, uses the vocabulary that is most easily understood in its simplicity and interpretative value (Angel, 2002; Baraga, 1976; Crawford, Peterson, and Wurr, 1967; Danziger, 1978; Hallowell, 1975; Hickerson, 1962; Kroeber and Kluckhohn, 1952; Ross, 1992). It was developed by this author in collaboration with the development of the theoretical Cultural Specific Approach and the *culturally-rich* people, with the explicit desire to accurately capture their expressions of health and life while living on reservations.

## 2.4 Responses of Native Spiritual and Cultural Beliefs that Alter Medication Experiences

Patient responses to medication experiences are harder to predict within the native culture. In this research study, medication experiences of native reservation residents who are substance use disorder patients and may be in treatment are observed, and their reactions and comments are analyzed within a cultural lens to learn their perspectives regarding the course of medication therapy. The data is expected to reveal a rich source

of helpful contributions to understanding the holistic needs of rural Native populations better. The retrospective analysis allows an additional study to look back and see where changes or possibilities lie in constructing a different strategy to predicting patient behavior and their medication experience in context back to the literature and Cultural Specific Approach.

Duran (2006) gives cause to reexamine the native patients' experiences with spirituality and cultural practices that affect their medication behavior. Stringer (2018) asserts that the native patients' belief teachings are underpinning the intent for health seeking behaviors, a step in understanding the desire and need to achieve a healthy, holistic state of 'being,' balanced mentally, spiritually, and physically. For example, the ideas of spirituality and patient-centeredness represent a relationship together. When prescribing a drug therapy, these two areas are important to address for optimum understanding of what is a normal response for native people. It is not appropriate within native belief to separate these aspects.

When prescribed a medication therapy course of treatment, patients may not take the medication for fear of insulting higher powers who created the individual; and, compliance with a Westernized approach to medication means a lack of faith in the Anishinaabe spiritual realm of creation. Illness can be caused by man's pitiful nature and burdened on the part of the individual that results in sustained sickness. Illness is also a condition that may not be translated as a disease state. For native people, the pejorative concept of illness is unlike the current reasoning. Illness is, however, treatable with native medicine practices. For native people, the confusion begins with illnesses that are not

curable through native remedies and most do not understand where it came from. Common afflictions are thought to not need treatments from medications because the native cures have proven to be more efficacious, and those cures do not make them more ill, like 'whiteman medicines' or what they may be prescribed in doctor's visits. Most native patients prefer to see a medicine man or healer and wonder where the native healers are when attending the physicians' office (Minnesota Department of Health, 2012).

Cultural "sick belief" models are by nature opposite in theory, and distinctively revealing for American Indians. Sickness is seen as a challenge and by getting extremely ill, quite near death, can initiate the patient to higher recognition status, if they survive and conquer the illness. The recovered patient is rewarded and indwelt with spiritual animal/plant (creation) powers and bestowed forces within spiritual healing ceremonies. These ceremonies can be isolated, as in dreams and visions, or gifted as in the jaasikiid, shaking tent. Historical documents chronicle anecdotal evidence of 'sorcery, or supernatural powers' upon healing and ethnobotanical knowledge (Vennum, 1983). From the 1940s, there were reports of cures and manifestations of supernatural powers that were unexplainable in acceptable versions of anthropological record (Blessing, 1979; Densmore, 1979; Hallowell, 1955; Vecsey, 1983; Vennum, 1983). Even to the current time, there are reports of cures after seeing a traditional healer, using traditional medicines.

## 2.5 The Burden of Public Health Policy for Tribal Nations and Insufficient Reporting Methods

Deliberate political policy in health care delivery that impacts the healthcare status of tribal nations is dependent on the interpretation of accurate data sources (Agency for Healthcare Research and Quality, 2014; Department of Health and Human Services [DHHS], 2014; National Research Council, 1996; O'Brien, 1989). For lack of better reporting methods from tribes and the reporting agencies, some outcomes seem positive but mostly, the majority of compromised health conditions (see Figure 1, section 'Affective or Compromised Health Conditions') observed on reservations (Minnesota Department of Health, 2003) may have been preventable. Now, the illnesses, unfortunately, manifest as acute states of chronic morbidity and increased mortality (DHHS, 2014, p. 61). Access to health care has not improved as American Indians, and Alaska Natives receive worse care than Whites for about 40% of quality measures (National Healthcare Quality and Disparities Report and Anniversary Update on the National Quality Strategy, 2015. p. 11).

## 2.6 Application of the Cultural Specific Approach Model and Innovative Health Thinking

A primary endpoint in this dissertation is to present an innovative design of 'health thinking' through the Cultural Specific Approach that radically changes how practitioners evaluate their patient's compliance and understanding of their medication behaviors to increase desired health outcomes. Innovations in redesigned health-thinking is an approach that joins the Cultural Specific Approach and Ethnographic Inquiry Methods in improving

health care delivery and access. In localized rural populations like reservations, no concept or technique is ever easy; quite the contrary, it takes innovative thinking and questioning that reflects the ideology behind a community partnership.

Reservations are described by residents as the most inadequate locations to build health centers due to the following: lack of water supply, technology deserts, internet gaps, and the inadequate medical workforce at mere shadows of what should be demonstrated as the highest demand for the most numbers of practitioners available. Low socioeconomic and social support of the funding agencies and other environmental deficiencies are common (Ross, Garfield, Brown, and Raghavan, 2015). As a consequence, reservation residents that are Medicaid eligible use the emergency departments (ED) to receive medical care, and in large numbers and frequent visits (Johnson, et al., 2012). This 'super-users' phenomenon drives up health care costs, but it may not avoidable in rural areas (Brenner, 2014).

Brenner (2014) has shown a significant economic and psychosocial improvement plan that organizes patient care management through care management team members who know the community. The community support services team consisting of a social worker (services), nurse, community health worker (transportation and navigator) and pharmacist visits the patient in the hospital, reviews prescribed medications, confers with doctors and daily nurses, and helps plan the discharge.

Brenner (2014) does not mention pharmacists in his plan, and the recommendation to expand meaningful understanding of personal medication education should be emphasized here to include the Pharm. D. trained pharmacists and Registered Pharmacists,

who as providers on federal reservations are essential providers of health care. Healthcare providers on the reservations have the least numbers of the workforce available, even though the need is the greatest. This is one of the most significant workforce capacity gaps between workforce numbers and healthcare disparities (Gaither, Schommer, Doucette, Kreling, and Mott, 2014). A vast increase in the workforce numbers of pharmacists and Pharm. Ds. would beneficially meet the medical service needs of native populations, as evidenced in other federal patient populations (Groppi, Ourth, Morreale, Hirsh, and Wright, (2018).

For many health initiatives on rural reservations, utilizing the trained Pharm. D. as a provider (Health Resources & Services Administration, 2018) is considered the best optimization of the provider workforce. In many cases in rural communities, when there are physician shortages, and the nature of the treatment can be directed by a Pharm D trained pharmacist with standing orders, thus alleviating the burden on physicians' workloads. It allows consistent communication between patients and provider, and unlike other professions, the pharmacist has a better understanding of the medication therapy goals for the patient, especially if they see them monthly or in some cases in the home or outpatient treatment, daily. For this study, the intent was placed on the pharmacist to lead the conversations between the provider and patients and other professional staff. The pharmacist taught staff nurses and advised patients with their medications and safe use of supportive devices. Many intermediary roles for patients in rural reservation clinics, FQHCs and servicing localized communities were effectively and efficiently managed by the administrative capacity and medication expertise of the Pharm. D. (Health Resources

& Services Administration, 2018). Utilizing the expertise of the Pharm. D. trained pharmacist improves the quality of care and complements the provider role in community health and medicine (Hepler and Strand, 1990; Indian Health Service, n.d.).

## 2.7 Utilizing the Reservation Medical Home Model and Cultural Transitions to Restorative Health

The Cultural Specific Approach is increasingly important as the patient is transitioned to home. The Cultural Specific Approach can be used adaptively to provide the support or integrate the social needs that are most familiar with the patient (see Figure 1). Team members, including the pharmacist, may visit the patient at home immediately after discharge and provide ongoing support (educational and therapeutic instruction) for two to nine months, including connecting the patient to the health clinic's primary care doctor, dentist, and pharmacist. The team accompanies him or her to appointments and helps line up needed social services. The time specification of two to nine months is a newly established protocol that links the pharmacist to the client for the duration of a therapy. Reservation health clinics have Community Health Care Representatives (CHRs), Community Support Specialists, Public Health, Wrap-Around Transition teams and Community Health Care Workers (CHWs) who are on-call as patients need their assistance. The goal is to support patients with the ability to manage their health on their own. In this example, the Cultural Specific Approach and EIM would be essential to gaining the trust and behavioral compliance with prescribed treatments (Duran, 2006), especially within the

dynamic parameters of the reservation clinic's medical home model. In all cases, the pharmacist is recompensed within the appropriate billing method, and the Cultural Specific Approach model supports the job description and rate of performance pay structure.

In this study, the qualitative evidence for these behavioral changes is discussed in the case study units of Cultural Expressions. Hallowell (1975) interprets the Ojibwe ontology, behavior, and worldview that reveal relevant transitions between the culturally value-laden characteristics (Diener and Fugita, 1995; Humphreys, 2012) of health belief for Anishinaabe community residents are often misinterpreted in comparative Westernized theoretical social and behavioral modeling (Hallowell, 1955). The ambiguity is mainly based on the less recognized association of Anishinaabe spiritual beliefs and daily activities that perfuse cultural beliefs (Blessing, 1977; Densmore, 1979; Doran and Littrell, 2012; Dunning, 1959; Emerson, 1965; Hallowell, 1975).

## 2.8 Ethnographic Inquiry Differences in Interpretation of Survey and Practice Interactions

Survey questions regarding cultural practices often commit informal fallacy (double-barreled) due to an incomplete understanding of the respondents' internal cultural, ethnographic orientation and interpretation. For example, questions such as: 'Do you rice? Do you use a sweat lodge? Do you pick berries?' are the cause for concern and uncertainty for most Native American respondents. More often the respondents are confused by the question that involves spiritual tendencies (sweat lodge) and cultural daily living activities (ricing and collecting berries), and consequently, the interpretations of the results are misinterpreted, and interviewer biased (Summers, 1969). Spindler and Spindler (1990)

describe these questions that fail to differentiate particular methods and cultural parameters symptomatically as ‘mainstream’ American, the referent ethnic class.

Characteristically, native respondents respond to survey questions through a host of internal memories embedded within their psyche and display different behaviors corresponding to those interpretations. These internal interpretations are indicative of elders aged 60 and older who either have lived through War-era experiences (‘lived’), baby boom adults aged 40s to 50s who recall stories of their parents and grandparents’ histories (‘middle age’), or early adults aged 20 to 30 years old (‘young adults’), and the responses are answers not accurately representing the intended purpose of the contemporary questionnaire. Moreover, contributing to the responder bias, the respondent answers the survey questions with the aim of ‘making the questionnaire a positive experience’ – the Hawthorne effect - since most individuals have never been asked to participate in a research plan. They give purposeful answers that they think reflect what the surveyor wants to know but do not reflect what they think.

Another reason is the type of response category may be insulting to the responder, so they do not finish the survey, or they provide false answers for the rest of the survey, picking out only the questions they, by choice, want to answer. In that case, a simple open-ended question in qualitative methods is more useful. The responder will give much more information if the communication part becomes recognized in contextual terms with which they are familiar (Summers, 1969). Frequently, respondents will be unable to answer the survey questions accurately. Some responders will only respond to the questions they recognize and ignore others. These incorrect responses could be due to many reasons,

but most often responders give unclear responses due to their unfamiliarity, respondent fatigue, faulty recall, question format, and question context.

Literature informs us that researchers and providers working within American Indian communities, especially on rural reservations, describe the most often discussed challenge as how to communicate respectfully with American Indian residents. In as much as we speak of maintaining the scientific validity of a research instrument that captures the essence of native perspectives, the shortfall reminds us that there is more to be done to address this concern. For example, residents (respondents) raise questions about the methods and characterizations portrayed overall by the subsets of negative constructs and the questioning of mental health, social living, scales of measurement, and personal physical weaknesses. While positive subconstructs of strengths, triumphs, resilience, overcoming frailties of the physical kind, adherence to the native lifestyle and others are not represented. Negative constructs do not capture the demographic representativeness of the elements of Anishinaabe lifestyle, they feel are essential to their social structure, spirituality, and whole health identity. More importantly, American Indian respondents would prefer to answer survey questions they recognize within descriptors of their environment. Some envision the requirement of adding the fundamental component of the Cultural Specific Approach to frame the rest of the questioning methods in quantitative and qualitative research.

Hall (1976) describes previous health models that were designed for the 1950s and ‘60s social intervention programs have historically failed to capture the core premise of relationship building, a teamwork approach. This teamwork partnership, based on familial

love and devotion, exemplifies the psychosocial bonding (love) on which people thrive and in the case of study findings show the positive significance of turning lives around from addiction or habitual unhealthy practices. Even more, using misappropriated behavioral processes that fall short of describing the health belief of Anishinaabe people. Thus, the purpose of the Bimaadiziwin Cultural Specific Approach is to define its primary status, resolve the gaps in knowledge and literature, and improve cultural practices of the health belief model that best characterizes the Anishinaabe people who live on rural reservations.

## 2.9 Approach and Contribution of the Study

This study attempts to make two contributions to the literature for health research, the Cultural Specific Approach model as a first theoretical construct and the EIM. The first contribution is an *a priori* position of the Cultural Specific Approach for a community of people. For the Anishinaabeg, Bimaadiziwin as a construct, presents a logical approach for investigators to understand their health beliefs and concerns and is used to conceptually synthesize the similarities and intralocularity of traditions, and cultural norms among Anishinaabe tribal members. The new approach provides clarity of comprehension of the indigenous interpretation of healthcare responses from previous designs of qualitative methods (Angel, 2002; Barnes, Adams and Powell-Griner, 2010; Basset, Tsosie, and Nannauck, 2012; Doran and Litrell, 2012; Mataira, Matsuoka, and Moreilli, 2005; Meghani, Brooks, Gipson-Jones, Waite, Whitfield-Harris and Deatrick, 2009) and processes of evaluation (Hall, 1976; McLeod, 2007, Minnesota Department of Health, 2001).

The second contribution to literature is the EIM that explains the patient's expectations for healthcare and medication treatment experience. The EIM is an extension of design-based questions that utilize intrinsically phenomenological or grounded theory epistemology based on the specific cultural norms. This step is critical to establishing trust (Duran, 2006) and a relationship to the participants' common health competency (Ferguson and Candib, 2002; Brach and Fraseriretor, 2000). The EIM asserts that culturally concordant questions are the most effective in establishing a bond of understanding for the patient-provider relationship (Atwood et al., 2016; Borkovec and Costonguay, 1998; Cuevas, O'Brien, and Saha, 2017; Ferguson & Candib, 2002; Kutob, Bormanis, Crago, Senf, Gordon, and Shisslak, 2013; Suganami, 2009).

## 2.10 Theoretical Framework

The best approach to present the tribal data as empirical evidence for the study is the Nomothetic Approach (Allport, 1937). The Nomothetic Approach is utilized to develop the baseline competency statements that presented to a panel of indigenous health experts describing the past, present and future aspects of their medication experience. The findings of the Nomothetic Approach are analyzed to identify areas of agreement and problem areas about the future of healthcare and medication experience from a cultural lens based upon the historical value of the Bimaadiziwin Cultural Specific Approach. Experts from the reservation and pharmacy profession will collaboratively develop new plans for ensuring medication experiences are better understood from the cultural patients' perspective.

These findings shall:

1) Determine any differences in tribal populations of Anishinaabe living on

reservations regarding the impact of the Bimaadiziwin Cultural Specific Approach to Health modeling.

2) Determine if differences in acknowledging Bimaadiziwin Cultural Specific Approach to Health Model impacts patients' medication experience.
3) Categorically place principles of Bimaadiziwin as the Cultural Specific Approach Model of the Anishinaabe to align desired or beneficial outcomes of the patients' expectations in their medication healthexperience.
4) Evaluate any differences in a complementary approach to historical phenologic plant medicine usage regarding the use of spiritual healers and traditional medicine.

This study achieves unique precedence in five areas:

1) Bimaadiziwin Cultural Specific Approach clearly strengthens the premise of health, mind, and spiritual constructs in the manner Anishinaabe people identify and codify attributes defining the presence of their 'living' culture.

2) The Cultural Specific Approach exemplifies a typology that is essential to changing health status in medically underserved areas and those with limited health care access.

3) The Cultural Specific Approach challenges current perspectives on health care delivery and assumptions using non-native abridged health belief models.

4) The Cultural Specific Approach presents core strategies that will influence provider-patient interactions and guide future research initiatives in improving

health inequities for American Indian people who live in rural communities.

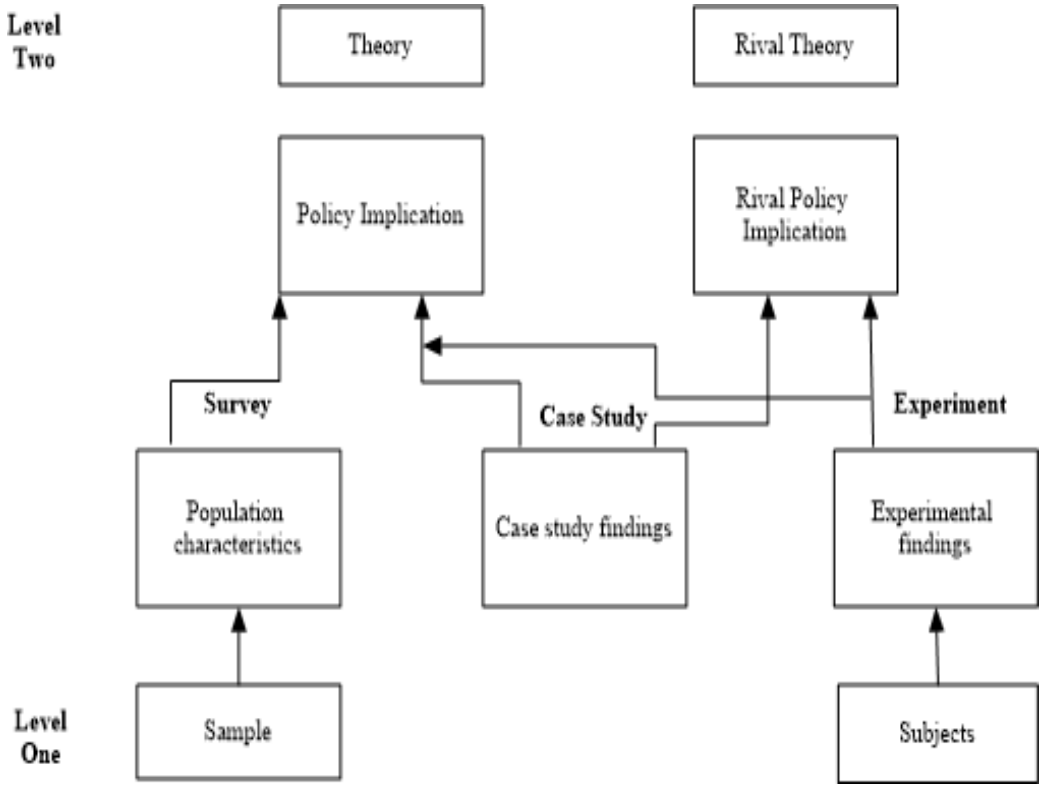
5) The Cultural Specific Approach develops a collaborative partnership with pharmacists as a provider in strengthening positive aspects of the medication experience for patients, encouraging trust response, and decreasing future barriers to health literacy.

This study examines issues in health care adherence, medication compliance, and the resolute mindfulness to change present health behaviors through case study research (Eisenhardt, 1989). The Bimaadiziwin Cultural Specific Approach best demonstrates the features and consequent behaviors of the Anishinaabe culture. Through the overall contributions of pharmacists' knowledge of medication therapy management and professional skills, these changes can influence positive health outcomes of residents in any rural communities.

The theoretical analysis for the Cultural Specific Approach study is best explained in Yin (2014). Figure 2 shows a graphical interpretation of this study's findings or design. The theoretical framework displays two levels of an analytical approach for where the Cultural Specific Approach theory fits and differentiates from the subsequent experimental and case study conditions. The focus of the Cultural Specific Approach study is Level Two and is designated as 'Theory." Codification of the Cultural Specific Approach study, and theory is at Level Two, according to the interpretation of Yin (2014, pg. 40), who describes generalizations derived from the case study research (Eisenhardt, 1989) in Level One and the theoretical propositions as groundwork, contributing to advanced Level Two analytical theory. Considering the recent review of the literature, the generalizations of health-

specific approach for Anishinaabe health belief construct are at the Level One (sampling) from lesser-understood population characteristics and end up  at make-shifting policy, but do not advance to qualifying the foundational theory of Level Two that transforms practice and informs innovative modeling constructs for generalization.

Figure 2. Theoretical Framework of the Cultural Specific Approach to Health Model




Level One and Level Two differentiate analytic flow in research design. Reprinted from *Case study research design and methods*, 5th ed. by Robert Yin, 2014. Retrieved April 8, 2019.

The theoretical framework for the Cultural Specific Approach study is uniquely designed, placing the Bimaadiziwin Cultural Specific Approach as the prime construct (see Figure 1). Contrasted to other models that focus on stress measures, low socioeconomic status or traumatic descriptors to define the American Indian status of health and medication adherence experiences that indiscriminately place value-laden approaches that seek to describe this population (Wan et al., 2007), the Cultural Specific Approach restores the Original People's philosophy of Health and Wellness (Waisberg and

Holzkamm, 2001; Vennum, 1982), preserving their irreplaceable cultural (White, 1982; Buffalohead, 1983) and living spiritual identity (Angmarlik, Kulchyski, McCaskill and Newhouse, 1999; Benton-Benai, 1979; Churchill, 2001; *Clear Communication*, n.d.; Waisberg and Holzkamm, 2001).

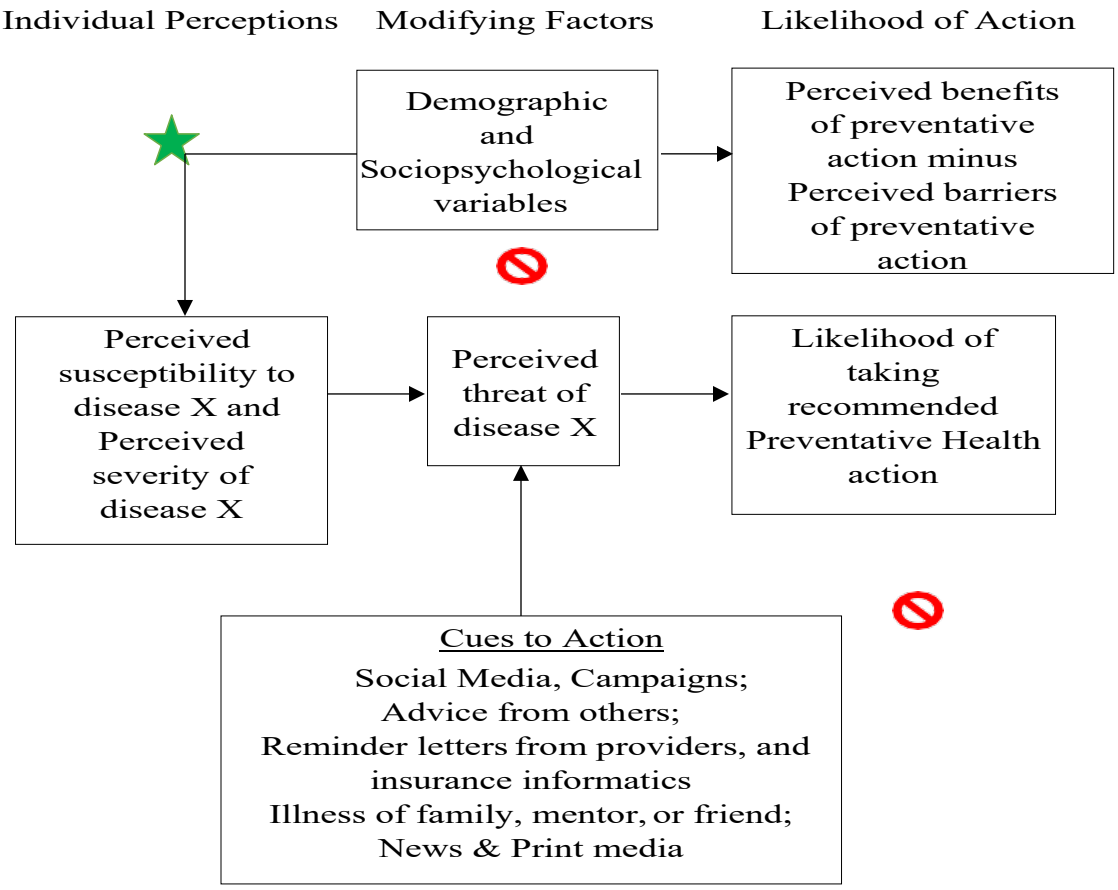
The leading feature of establishing an *a priori* cultural belief as a necessary component in indigenous Anishinaabe research stems from recognizing that the Bimaadiziwin Cultural Specific Approach can influence health communication, including dialogue that encourages participator behaviors, language, customs, beliefs, and perspectives (see Figure 1). The Cultural Specific Approach recognizes that cultural respect is also critical for achieving accuracy in medical research (*Clear Communication*, n.d.). *Clear Communication,* (n.d.), emphasizes poor planning in medical research, i.e., planning that does not take into account principles of cultural respect, may yield inaccurate results. There are federal organizations whose missions design various public engagement forums. These forums are to foster opportunities, advance health equity, improve quality, and help eliminate health care disparities by providing a framework for individuals and health care organizations that devise culturally and linguistically appropriate services (Gomez, Charnigo, Harris, Williams, and Pfeifle, 2016).

Health belief theories inform health interventions, though none inform how to share strengths and integrate perceived experiences of specific healthcare (Brach and Fraserirector, 2000; Hallowell, 1955). Throughout the study, questions framed by the nomothetic method capture information from the history of Bimaadiziwin to build the framework in proposing a general theory model for proposing a scientific, culturally-based

health practice and theory building model. Do these underpinnings press reflexive questions of how might a native lexicon in the participatory process be best back-translated to improve a practitioner or researcher's understanding of the medication experience? Today, there are more nuances of how medication is used legally and otherwise (codeswitching for a street version of medication slang). So then, the discussion of medication and a normative cultural specific approach shifts to a more useful model when the right questions are understood as a pharmacist. Moreover, how can these questions work to improve collaborative action to modify pharmacy practice among Native health programs? Accordingly, what consequences can be attributed to transforming the health belief models that reflect a community-specific approach to health?

The Cultural Specific Approach is designed to address behavioral, cultural and spiritual health, and psychosocial (wellness-positive) interventions that without its antecedent position, intervention, illness, problem behaviors, and compromised health measures are less understood. The design of the Cultural Specific Approach (see Figure 3) aims to inform and predict a greater understanding of cultural and spiritual health behaviors for native tribes through a strengths-based theory and in this study, Bimaadiziwin, that is implicitly recognized for the Anishinaabeg.

Figure 3. Western Health Belief Model and Cultural Specific Approach to Health Model Construct Placement




Adapted from MH Becker and LA Maiman, 1975, Medical Care, Copyright by Lippincott, Williams and Wilkins. Retrieved May 2017.

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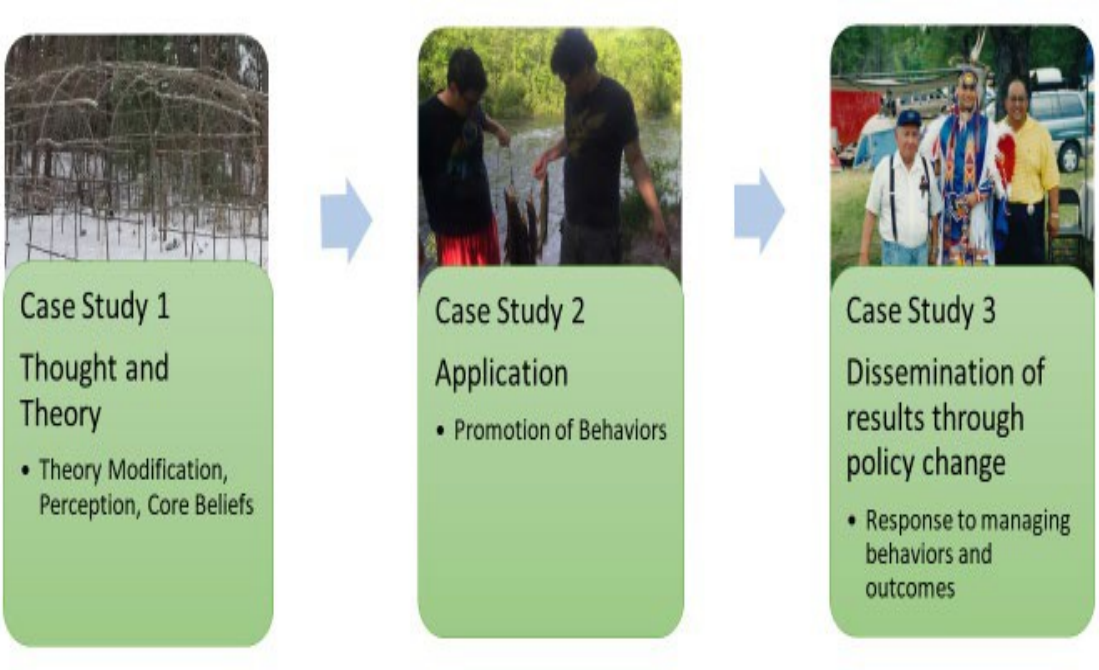
Figure 3 displays a green star symbol. The green symbol is distinguished as the optimum recognition for the *a priori* Cultural Specific Approach. Compared to the antecedent approach of the Cultural Specific Approach, the review of the literature reveals the rival theory of the cultural emphasis is usually relegated to lesser positions in health belief models, and this positioning of the cultural belief is noted midway in therapy or last place after therapy (Becker and Maiman, 1975). The midway and last place of cultural belief for natives is designated by the red symbol and not acceptable for optimum therapy.

The three case studies that form the basis for the application of this study can reveal the breadth of the Cultural Specific Approach theory in correcting the omitted first step in bridging restorative health within a community (Figure 4). The most efficacious approach to qualitative and quantitative approaches to understanding the community and its health begins with the people. More likely, the survey approach gathers the demographics and important features of the community; yet, there often are more instances not captured within standard questions that can really open up a better picture of the environment in which the patient or client spends their time. For Native people, their community is very important and the activities that they participate in are highly meaningful. Therefore, fostering engagement of community participation and a cultural lens likely enhances the reception of the participants or respondents within the study.

The case studies exemplify the Cultural Specific Approach from the start and begin with the perceptions of the people. These perceptions of the culture create the modifications needed to explore the core beliefs behind the theory of the Cultural Specific Approach in case study 1. Case study 2 progresses with the application of cultural factors that resonate with the community's needs to promote health and engage achievable results. The progression of healthcare responses from the community and pharmacotherapy are a crucial step in the application of the Cultural Specific Approach in this study. Case study 3 achieves measurable results through the combined care response of the provider and client and moves the potential policies forward through the healthcare organization administration for review. All steps within the Cultural Specific Approach are a progression and built upon the initiation of the first step through the last step.

Figure 4. Framework of the Case Studies within the Cultural Specific Approach Model




Case study 1. Winter wigwam in Wisconsin.
Case study 2. Two Native youth fishing at the Billyboy dam, July 2014, WI
Case study 3. Three generations of tribal members participating in an annual celebration, Honor the Earth powwow, July 2011.

Each of the visuals are essential in this dissertation to portray the significance of the phenological or seasonal, traditional activities, the spiritual and healing practices, and the concept of the happiness or wellbeing that are inherently attributed to native peoples.

While there are a number of examples that can be depicted, these visuals illustrate a concise, but compelling snapshot of the importance of interpreting and understanding the survey demographics of a community of people, especially on rural reservations. The visual in case study 1 depicts a winter picture of a wigwam lodge that is part of the Anishinaabe life and core belief system. Case study 2 image shows a healthy approach to activity and food sustenance, and both represent demonstrable Anishinaabe community

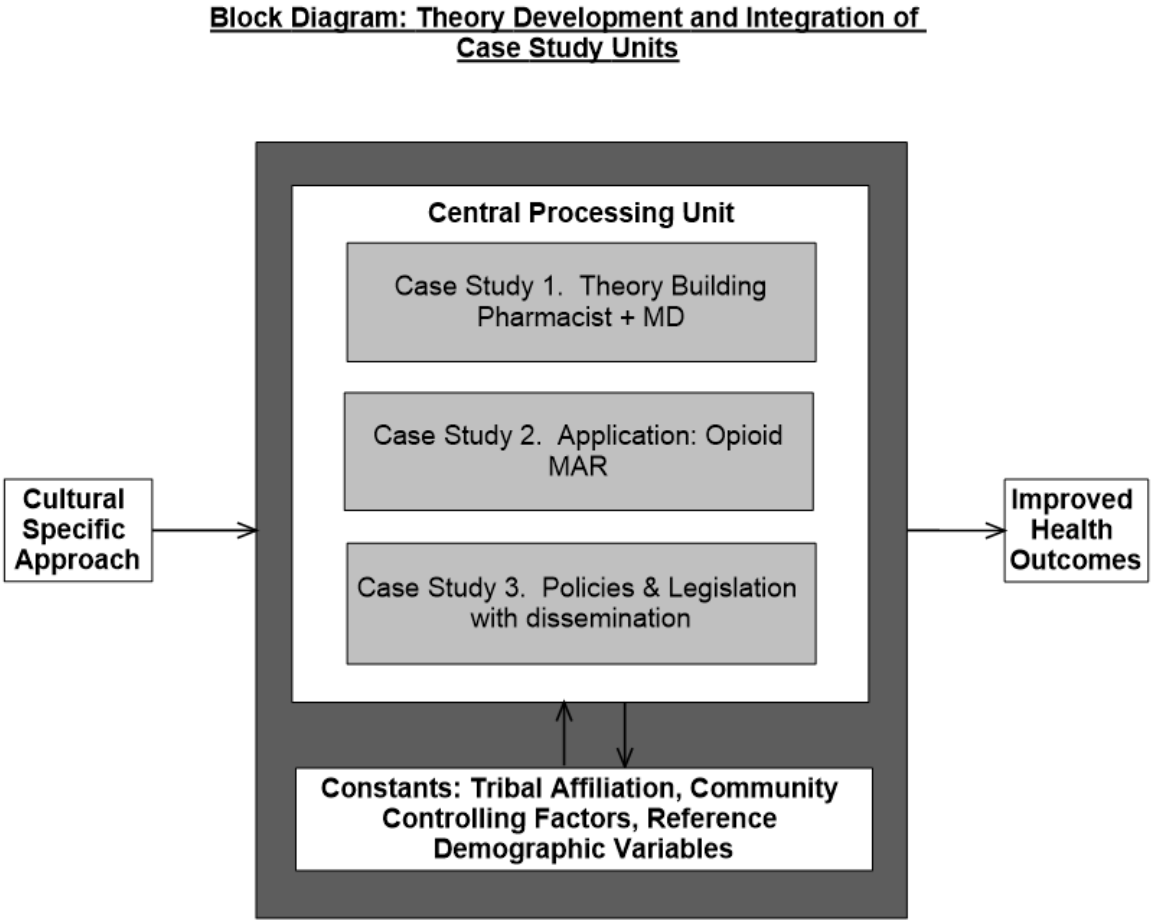
traditional practices. Case study 3 image represents three generations of tribal members who have influenced change and are active participants in the formulation of behavioral health, education achievement, and wellness initiatives.

The collective images and case studies pose a reminder of the historical elements that influenced my decision in selecting this dissertation topic, the Cultural Specific Approach, a distinct theory that raises a meaningful theory modification in comprehensive healthcare analysis. The cultural identity of the Anishinaabe people is complex; but, holistic, and the objective to assert the *a priori* Cultural Specific Approach guides better understanding of how to transform healthcare for their community. If we understand the collaborative reasoning that pharmacy practice and cultural specificity have in common, the easier it is to streamline the engagement of the patients when it comes to evaluating the progress of their clinical goals of therapy (Cipolle, Strand, Morley, 2012). For many native people with multiple (acute and chronic) conditions, living on rural reservations, they have not had the care and evaluation of a pharmacist. The significance of a visual representation (preferably in-person) is a distinguishable part of the integration of the clinical pharmacotherapy and new practice model that represents the pharmacist-led initiatives within the community and pharmacy practice approach.

The topics of the individual case studies detail the polarizing effect that opioid addiction held on clients who were vulnerable. Compared to the cultural attributes that were primarily protective factors of the Cultural Specific Approach, integrating the case studies as part of the cultural framework developed the progression toward a complete model. The theory development and the integration of the case study units explain the

progression of the comprehensive Cultural Specific Approach model (Figure 5).

Figure 5. Three Case Study Questions in Relation to the Cultural Specific Approach Model




The analytic case study progression of the causal relationship methodology flow chart from **thought and theory development in Case Study 1**: *An Informed Method Using the Cultural Specific Approach: Supporting the Primary Care Clinician Response to Crisis After Overdose*; to **application of theory in Case Study 2**: *Pharmacist-led Community Engagement and the Role of the Pharmacist to Understand Medication-Assisted Recovery with the Cultural Specific Approach.* Finally, **dissemination of results through policy**

**and legislation** in Case Study 3: *Effectiveness of the Cultural Specific Approach to Health to Initiate Policy Changes within Community Clinics.* Tribal Affiliation, and constants such as Person-oriented demographics serve as guides to develop criterion - mixed method factors. Rather than only serving as demographics, tribal affiliation, gender, and roles preclude the cultural specificity of each community, thus contributing to understanding nuances of community specifics. The model then becomes innovative using a convergence analysis technique with the Cultural Specific Approach as an antecedent construct. Convergence analysis (Yin, 2019) utilizes all data in concordance with a nomothetic approach where all data represents the greater population and not individualized to a few.

# CHAPTER 3

## LITERATURE REVIEW

The review of the literature significant to this study involves four major sections.

Section One contributes a preliminary look at the prominence of Bimaadiziwin within the cultural specificity of the Southwestern Anishinaabe people (Vecsey, 1983) in the rural settings of the federally established reservations in Minnesota and Wisconsin (Figure 6).

Figure 6. Geographical Location of the Southwestern Ojibwe Nations

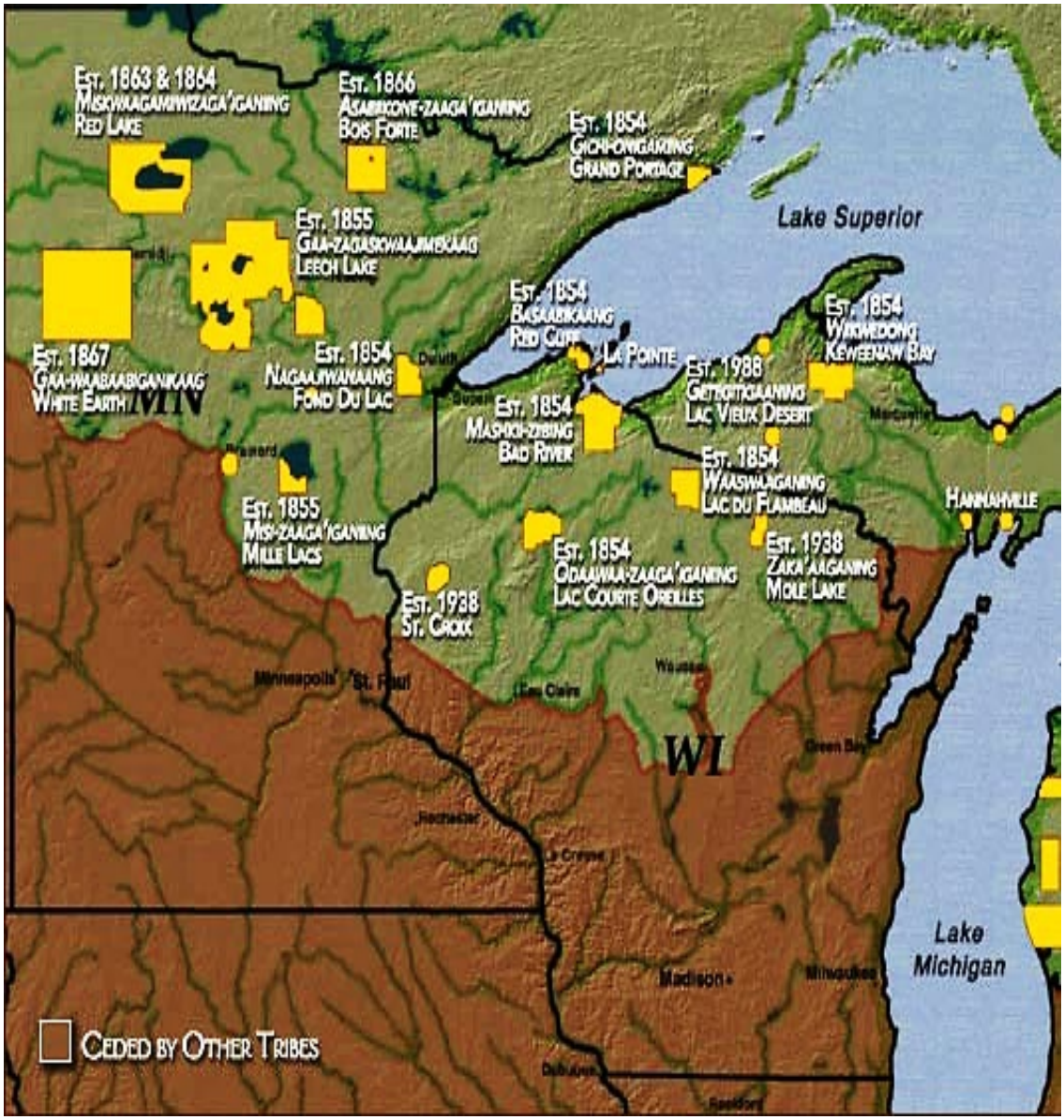

Location of the Southwestern Ojibwe Nations. Retrieved April 20, 2016 from https://smediacacheak0.pinimg.com/736x/da/9e/99/da9e999e728503838db402f1b095f00 c.jpg

Bimaadiziwin translates most closely to 'life' in the original language of the Anishinaabeg, also referred to as Chippewa (Blessing, 1977), Ojibwe (Catlin, 1841), or Anishinaabe (Benton-Benai, 1979). Bimaadiziwin is the overarching model for health, living, and spirituality construct. It is important for the study to capture the historical value and characteristics of this model to correct some of the flawed assumptions that indiscriminately express lesser known features of an enduring race of people with a rich heritage. The study objective to codify the Cultural Specific Approach as an *a priori* construct establishes a new framework of healthcare modeling through the relationship of the Anishinaabe peoples' cultural specific construct of *Bimaadiziwin*. In this study, the profession of pharmacy is highlighted as providing the bridge to transformative interaction between pharmacist and patient, motivating a trust response, and validating the cultural collaboration of complementary pharmacologic knowledge exercised in mind, spirit, and behavioral intentions to change.

Section Two of the review is an abbreviated account of social or collective community history within reservation life (Figure 7). Living in rural communities has predominant cultures unique to small towns, villages, and reservations. For the majority of urban health policies, the characteristics that are formalized in health initiatives are vastly incongruent to life in rural villages. Needs are different, but recognizable once distinguished. Resources are scarcer, and always recognizable because the funding is not enough for sustained growth, just enough for a few months of the year. Under these circumstances, healthcare is not always the first priority for patients and at times, the circumstances can affect long term chronicity of illness.

The rural villages and small communities are prominent; and host long-held traditions that distinguish ways of thinking and ways of behavior.

Figure 7. Establishment of Anishinaabe Reservations in Wisconsin and Minnesota




Reprinted from *Ojibwe Nation Reservation Map Waasaa inaabiidaa* April 20, 2016. Retrieved from http://www.ojibwe.org/home/episode2_rez_hotmap.html

For native reservations in Region V, the service area for the Indian Health Service, 34 tribal reservations depend on categorical healthcare funding to preserve, though limited, access to full-service health clinics with clinicians and providers. Sovereign tribal reservations are represented by the chairmen of the Chippewa Federation (CF) in Wisconsin and the Minnesota Chairmen of the sovereign Minnesota Chippewa Tribes (MCT). Organizations such as the Midwest Sovereign Alliance for Tribes (MAST), the Great Lakes Area Tribal Health Board, (GLATHB) and the Great Lakes Inter-Tribal Epidemiology Center (GLITEC) are recognized champions of keeping the needs and resources of native reservations at the forefront of negotiations with conservative federal consultations, such as the Bemidji Area Office (BAO) of the Indian Health Service (IHS), Centers for Medicare and Medicaid (CMS), and Centers for Disease Control (CDC) and Substance Abuse and Mental Health Services Administration (SAMHSA). On the national level, tribal policy boards ensure best collaborations align through the partnerships of the National Indian Health Board (NIHB) for health, National Indian Education Association (NIEA) for education, and the National Congress of American Indians (NCAI) for policies that affect American Indian and Alaskan Natives.

This perspective reveals the unique inspiration that Bimaadiziwin, as an example of tribal cultural and spiritual life, captures revealing patients' thoughts in ethnographic interpretation and assessments of their personal medication experience, particularly in chronic diseases such as Diabetes Mellitus Type II (DBMII) and substance use disorder (SUD). The literature focuses on the role of the pharmacist in providing medication in medically underserved areas, limited medical access due to environmental barriers and the

socioeconomic disparities that are compartmentalized and generalized to the extent noting that all American Indian reservations are located in rural geographies (Crawford, Peterson, and Wurr, 1967; Danzinger, 1978). Further examinations of the national survey reveal the noteworthy characteristics of job stress that rural pharmacists experience (Gaither et al, 2014), exemplifying for most practitioners, a pragmatic and altruistic understanding of the commitment these rural pharmacists choose in practicing in these medically underserved and impoverished areas (The Merriam Report, Institute for Government Research, 1929).

Section Three of the literature review concentrates on the merit and critique of the Nomothetic methodology (Diener and Fujita, 1995) that was chosen to explain the Bimaadiziwin Cultural Specific Approach. Here, the available literature invites discussion on sociological (Dunning, 1959; Gustafson, 1997), behavioral (Duran and Duran, 1995), and psychological validations (Jung, 1963), using the nomothetic ideology instead of an ideographic approach (Nichols, 2011). The nomothetic approach is uniquely appropriate in explaining tenets of American Indian spirituality and health belief expressed in Anishinaabe perspectives (Vecsey and Vennum, 1990). Nomenclature and best practices in native cultural competency that enhance patient perceptions of health and thereby, promote a point of care treatment effects models are shared (Shanley and Luz, 2003). Fundamentally, the revision in Cultural Specific Approach theory design will contribute to clarifying the misconceptions underlying the processes of health belief toward medication therapy management principles.

Section Four describes the integrative roles of the practitioner that combine Cultural

Specific Approach and the beneficial participatory process that intentionally restore or redesign instruction in cultural attributes and participation for pharmacists who practice in medically underserved areas. An emphasis on redefined population characteristics is explained to equip the practitioner better in how to communicate, understand the beliefs present in their practice continuum, and the effects of seasonal activities on therapeutic regimens. These are all expanded medication therapy management services that are relevant to changing the disparities in health education outcomes.

### 3.1. Section One: Bimaadiziwin Cultural Health Belief Model: One Purpose

There is a considerable body of literature describing health belief models and spirituality among ethnic participants (Wan et al., 2007; Hall, 1976). Regarding the practice of cultural competency and congruency in healthcare with indigenous people; specifically, there are none that employ the original Anishinaabe Cultural Specific Approach in the development of best patient-centered research practices. However, if we understand the iterative nature of traditional teachings and regard them as a 'living' language, and not structured by time, there are no bodies of literature that can inform an Anishinaabe person without reference to their cultural specific approach of Anishinaabe living, (i.e., Bimaadiziwin). The relationship cannot be separated. For example, within the accepted ways of thinking of the Anishinaabe, the spoken words of all teachings were meant to be communicated directly, whether in person, dreams, events, even in *spiritus sanctum* across generations. It was exceedingly rare to see examples of conversations between elders or teachings recorded until the present anthropological methods preserved valuable linguistic record (Vennum, 1982) .

Customarily, instruction and teachings informed community members through the spoken Ojibwe language that recognized the interaction of heart, mind, and soul. Anishinaabeg of all ages understood tacit, philosophical tenets in a culturally spiritually-fluid terminology, and these were the first oral teachings. First Speakers have defined Bimaadiziwin, and its core components, like Grandfather (Mishomis) and Grandmother (Nokomis) teachings (Benton-Benai, 1976; Kelly, 2003) that fulfill the central driving cogency of spirituality for Anishinaabe patients. Based on the singular, historical facet of Bimaadiwizin as the Anishinaabe Cultural Specific Approach, the combined outcomes of this treatise reveal a renewal in practice integration based on informed competency in health practitioner education, best practice outcomes that utilize new correlations between data transformations and relevant information for practitioners to improve relationship care.

Aside from accentuating the purpose of the literature review, another fact remains. There were no ethnographic studies or current models that accurately depicted the significance of Anishinaabe health belief, understanding that it encompassed the overarching Seven Teachings of Health and Life constructs (Benton-Benai, 1979) and had a bearing on the beliefs and life practices of the Anishinaabe. Essentially, it was omitted even as the actual evidence from ethnographers, anthropologists, and practitioners in various fields of science who for some, attempted to describe the Anishinaabe population and their health status in ethnographic documents from a Westernized perspective (Baraga 1976; Barnouw, 1977; Brach and Fraserirector, 2000; Brave Heart and DeBruyn 1998; Catlin, 1841; Churchill, 2004; Doran and Litrell, 2012; Duran and Duran, 1995; Garroutte,

Goldbergh, Beals, Herrell, Mason, and AI-SUPERPFP Team 2002; Flannelly, Glaek, Bucchino, and Vaine2006; Mataira, Matsuoka and Morelli 2005; Mac Donald, et al. 2015; Meghani, et al. 2009; Nagel, 1996; Roberts, 2003; Quimby, 1960; Rogers, 1978; Ross, 1992; Roufs, 2006; Schenck, 1997; Schmalz, 1991; Schoolcraft, 1978; Shifferd, 1976; Vecsey, 1983; Vecsey and Vennum, 1990).

### 3.1.1 Bimaadiziwin: Original Health Belief Construct

Upon reviewing the evolution of health theory and subsequent practices for Anishinaabe nations, the years of misinformation without correction has led to flawed assumptions in bio-behavioral health modeling. Vecsey, (1983), one of the early ethnohistorians, eloquently described Ojibwe (Anishinaabe) lifestyles during the 1940s depicts the 'good life' of the early Anishinaabeg in his ethnographic observations and offers one of a few descriptive, comprehensive portrayals of the aboriginal Anishinaabe customs from his point of view as an outsider and scholar. However, as he is not of the internal Ojibwe membership, his observations focus on changes he observes from the vantage point of 'religious' ceremonies he witnessed, and historical documents of travelers of times before 1880, which he supplemented with the testimony of acculturated mixed-blood Anishinaabe. Vecsey provides particularly useful accounts from other missionaries and travelers that describe the concomitant changes in Anishinaabe spiritual and cultural practices of Bimaadiziwin as the eras pass over the last three centuries. While these changes vividly describe the cultural and chronological underpinning of all health and life among the early Anishinaabe, the majority of stories retold by Vecsey and others maintain the veracity of Anishinaabe religious structure and content.

Furthermore, Vecsey describes the cultural symbols, songs in the Creation myths, and daily living practices – all extremely crucial to understanding what life was like for the Anishinaabe at that point in time – and assiduously describes his observations of the very philosophy (of Bimaadiziwin) which he attributes to religious fervor. Fragmented at best, his descriptions do not recognize or pinpoint Bimaadiziwin; but, emphasizes Midewiwin as the primary religious vista in these earlier belief experiences (p. 144). There is a subtle but decisive conceptual variance in analyzing these two tenets of the Anishinaabe religion. The reference correlates to the interrelatedness of the people and Creation, that affects behavior, and as Vecsey misses the central theme of *gakinaa awiiya*, "We are all related," referenced within the Bimaadiziwin belief that we are connected and interdependent with all life on earth. Anishinaabe tribal elder Teeple iterated, "We have a relationship with the Creator, and that relationship is the relationship with the environment" (as cited in Peacock & Wisuri, 2001 p. 4).

Coexistence with all living things is based on respect, sharing, humility, and responsibility--the heart of the Anishinaabe worldview. That centrality is the aim of this study which explains Bimaadiziwin as the appropriate model for guiding culturally specific health beliefs of Anishinaabeg. From this premise, the primary focus of the cultural specific health approach, transforms behaviors that demonstrate beneficial results to the patient.

Understanding that all tenets of religious leadership arose from the medicinal manidoog, leadership positions and teachings in Anishinaabe societies were inclusive of all animals and plant beings, man included, neither higher nor lower, but as the caretaker. Man's responsibilities were to care for the creation and family, and the plants were

abundantly given to health and healing. Anthropologist and ethnomusicologist Francis Densmore wrote "health and long life represented the highest good to the mind of the Chippewa, and he who had knowledge conducive to that end was most highly esteemed among them" (1939: 322; In Vecsey, 1993, p. 144). In this description, to further clarify, Midewiwin was the religious and healing society of the "Chippewas," or Anishinaabe; but not all Anishinaabe were a part of the Midewiwin Society (Lurie, 1980). Bimaadiziwin bridged that connection to the Midewiwin and the healing aspect, as well as the 'long life' or 'good life' concept, which exhibits temporal references to Bimaadiziwin, but this point is not explained in these firsthand accounts of Ojibwe life. Nevertheless, all Anishinaabe are given Bimaadiziwin, positively referenced by Densmore (1979) as a 'long life' as their gift of a living Cultural Specific Approach, *gaamiinigooyang* – "That Which Is Given to Us." The gifts of life from the Creator were meant to sustain the Anishinaabe in more ways than just responsibility and sustenance; but, also, that from which the Anishinaabe derived life itself. This acknowledgment of the symbolic and physical gift is foundational in treatment and healing for the Anishinaabeg. Bimaadiziwin provides hope and a path to healing.

An excerpt from Waasainaabidaa instructs (Peacock & Wisuri, 2001),

> *"These animals and the plants and everything else, their spirits feed our spirits…you know if we don't have the fish, if we don't have the deer, if we don't have the plants to feed us spiritually we are no longer Anishinaabe."*
>
> ~Gerald White, Leech Lake Anishinaabe

Peacock and Wisuri expound that the traditional Anishinaabe subsistence lifestyle is grounded on the cycle of the four seasons (2001). This lifestyle reflects the Anishinaabe

worldview where the individual is dependent on the group, the group is dependent on nature, and nature is dependent upon the supernatural for survival. This web of interdependence maintained a balanced relationship with all living things, in a highly sustainable economic system (Peacock and Wisuri, 2001, p. 5).

In addition to long life, Vecsey (p. 145) observed the continual connections between the Ojibwe religion and health in relation to pertinent causes and cures of illness. Thus, 1950s models of bio-behavioral health assumed native health beliefs were also based on social theory scales (MacDonald et al., 2015; Hall, Reise, and Haviland, 2007) that defined sociological and societal health belief from an etic perspective (Hallowell, 1975; Jung, 1964). This assumption juxtaposed behavioral transformation of Western "thinking" onto long-held beliefs, rather than taking into account the personal stories and accepting the relevant communication Anishinaabe contributed to the historical and present documentation of their health beliefs (Berkes, 1993). Ultimately, this "Westernized" thinking undermined meaningful connections of spiritual Midewiwin, the healing tenets of the Grand Medicine Society of the Anishinaabe and the 'long life' healing directive of Bimaadiziwin.

In a short time, the cultural health belief of the Anishinaabeg was omitted in theoretical constructs until now when the need to understand addiction and chronic illness is at a crisis. Within a nomothetic span, the Cultural Specific Approach provides the link of how health and healthcare improve for populations such as the Anishinaabeg. It is this intention to codify the theory of cultural specificity that drives underlying general health beliefs for theory building and not just collect facts without logic.

Bimaadiziwin is a *living* conceptualization of cultural praxis and the spiritual protean nature of the Anishinaabeg, as thoughtfully revealed within their daily prayers, activities, and native perceptions of life, not restrained within temporal boundaries. Grasping the conceptual properties of Bimaadiziwin as a 'long life' construct of health belief underscored psychological attributes that Hickerson (1970) and Vecsey (1983) described during the 1950s decline of the Midewiwin. Most significantly, observational studies from these earlier accounts of history and the post references to 'long life' suggest native people were, indeed, happy in the way they lived and were content as if their world had not changed – but the world had irreversibly changed, and Native Anishinaabeg were forced to assimilate or perish. These recollections are part of the nation's historical record that profoundly contributes to the Native Anishinaabe's preservation of seasonal and traditional activities, spiritual and healing relationships, and purposeful expressions of happiness. Alternatively, the gain of preservation of traditions lessened trust in Western progress whether presented to Native Anishinaabe for improvements in health, medicine, or psychosocial determinants because their culture was ignored at the beginning.

Native Anishinaabe people are aware that they are created "First beings, Spirit-beings, and Original Man." Nowhere in Bimaadiziwin teachings does it postulate that the created spirit beings are burdened with trauma and violent effects in the creation stories of man, as 'First Beings' from the Creator's First Gift of Life. This point is one of the most significant perspectives that affect the propositions and logic of current behavioral and social health theories on the healthcare of the Anishinaabe American Indian. Moreover so, this study examines the perspectives of Anishinaabe First Beings and uses evidence directly

from Anishinaabe rural reservation populations with several secondary analysis sources that Bimaadiziwin Cultural Specific Approach to Health Model belongs as the first health belief premise.

Further, of the many studies that focus on American Indian spirituality and health beliefs, there are none written from the mixed methods analyses of the specific Minnesota and Wisconsin Anishinaabe tribes that frame the geographic realm of Southwestern Anishinaabe in the United States.

### 3.1.2 First People's Perspective of Bimaadiziwin

This first section reviews the literature about the historical background of Anishinaabe health beliefs and the significance of Bimaadiziwin as is viewed in the First Peoples' perspective. First, what is Bimaadiziwin? Bimaadiziwin is the Anishinaabe origin construct of a happy life, a perfect gift from the Creator. At first it may seem Bimaadiziwin is an idealized cognitive concept; but, as historical accounts, anthropological field studies (Vennum, 1982; Densmore, 1979; Danzinger, 1978; Copway; 1850; Barnouw, 1977; Vecsey, 1983), and combined contemporary field work of the Anishinaabeg (Schenck, 1997; Ross, 1992; Newcomb, 2013; St. Germaine, 2014) suggest, Bimaadiziwin is not at all conceptual. Instead, Bimaadiziwin presents as a reified belief. Reified takes something metaphysical and regards it as a material or concrete entity. Jung (1933) was so mesmerized by the insights he experienced after meeting members of the Anishinaabe people that he conceptualized a distinct version of metaphysics based on Bimaadiziwin. Likewise, Bimaadiziwin emerges as a belief that pervades the 'thinking and being' of all Anishinaabe,

young and old. It is the realized discovery of an inner nonphysical joining of a native spiritual world here on *aki*, earth. Conservatively described as the pathway of life, a journey that belongs in the heart, mind, and soul, Bimaadiziwin is often expressed in song and observed in dance (Vennum and Vecsey, 1990). Native ways of thought capture visions that are guided by omniscient forces, beneficent and wise spirits that have seen the past, acknowledge the present, and visit the future for the Anishinaabe. Bimaadiziwin embraces Anishinaabe persons in the 'heart' of all creation, and it is this internal sense that blends the strength of resiliency and epistemological understanding that Anishinaabe is not bound to earthly frailties (Johnston, 1982; Vecsey, 1983).

Health and wellness are central components of the Bimaadiziwin framework. Johnston (1982) briefly discusses philosophical and spiritual tenets of the Bimaadiziwin health and wellness that cross-reference the foundational Seven Grandfather Teachings: Nibwaakaawin (wisdom), Zaagi'idiwin (mutual love), Minaadendamowin (respect), Aakode'ewin (bravery), Gwayakwaadiziwin (honesty), Dabaadendiziwin (humility), and Debwewin (truth). Overall, Bimaadiziwin presents an Anishinaabe overview of a keystone world, shaped by the Creator's hands and blended by celestial forces of nature before the frank colonization of Turtle Island, however meaningfully; it presents the key setting of *mino Bimaadiziwin*, the good life for the Anishinaabe. It is this view that predicates knowledge and values that fashioned the Anishinaabe foundation of social theoretical domains before the cataclysmic disintegration of their world at the arrival of the white man's culture and influence of maladaptation in acculturation (Vogt, 1957). Looking toward the future of research in health and wellness especially in response to substance

use disorders in the foundations of the theory, contemporary health belief models must include the Cultural Specific Approach as well to help guide understanding and acceptance of health needs across Indian nations.

Vecsey reports (1983), the Bureau of Indian Affairs (BIA) controlled the health services to 1955 with the creation of the Indian Health Services (IHS) within the Public Health Services by the US Department of Health, Education, and Welfare. The Indian Health Service discouraged traditional medicine and actively competed with the healers, even to the point of replacing the traditional healers with IHS nurses (Dejong, 2010; Vecsey, 1983, p. 159). The original teachings of Bimaadiziwin and other tribal practices were now kept in secret at the behest of Indian families that had forcibly lost their children to boarding schools, the torment of persecution to cast aside their tribal identities. The Anishinaabeg were now in the era of assimilation and acculturation. Bimaadiziwin, however, never lost within the Anishinaabeg, emerged again as singularly defined as the rightful *life* belief of the Anishinaabe culture and people.

### 3.1.3 Brief Anishinaabe Origin Story

The world begins within the mind and will of the Creator. The Creator placed the four colors of humankind in the four directions: the yellow color to the east, the black color to the south, the red color to the west, and the white color to the north (Kelly, 2014). In every direction of the sky was the endless expanse of the creation in which life began. The people of the four colors would come together and, abiding by their respective instructions, would thrive in the shared prosperity of the human family. Personal gifts, language, and instructions were given to each of the humankind beings by which to live in harmony with

all creation. The humankind beings were equal in life and the choices of their life, but each would understand the revelations of the Creator and would remember their story of life, Bimaadiziwin. Animals, flying, swimming, and crawling were presented to the Spirit Beings for their care and names. For the Anishinaabe, life is Bimaadiziwin, and its meaning for their names for both the humankind and animal-kind beings meant nothing more could compare with this perfection from Gizhi-manidoo, the Great Spirit, Creator, and the Supreme Maker of all things. For these reasons, Anishinaabe names presented at birth or other significant times in a person's life are considered essential ceremonial religious beliefs. As the Creator knew and therefore, taught human-kind, life had no beginning or end, everything that was ever continued to be, and everything that will ever be, exist in spirit. For the Anishinaabe, recognition of their ceremonial naming and care practices are intertwined in the creation of life and are not separate from the quality of their daily lives. Bimaadiziwin, then, is the completeness and totality of creation itself imbued with the spirit of the Creator. This tenet explains the existence of a protective factor for Anishinaabe humankind who do not acknowledge a sick belief model, especially so, as the creation of humankind was created well and wholesome.

When the Creator separated the earth and sky, he summoned four spiritual beings who in their divine essence were in colors we would come to see as red, blue, green, and yellow, the four Star Spirit ladies. The Creator bestowed the starbeings in the sky and for life on the earth, the Grandmother. The rocks, mountains, stones, boulders, gravel, small stones were called grandfathers. The moon was a spirit being, Grandmother-who- lights-the-Night Sky and appeared thirteen times in the care of the grandmother.

### 3.1.4 Turtle Island Revisited

Fred Kelly (2014) retells The Origin of Turtle Island and the healing story of the Anishinaabe. The turtle came down through Pagonekiishig and was placed on Turtle Island, the western hemisphere (Figure 6). Kelly describes the Turtle as one of the most exalted spiritual healers and benefactors of the Anishinaabe. These sacred roles are described with the meaning behind the shell and how the turtle is the principal messenger in the *jaasikiid*, shaking tent ceremony used in healing and blessing. There are thirteen scales in the Turtle shell and for the Anishinaabe represent the thirteen moons in one lunar year. The Anishinaabe honors the Turtle and this hemisphere as Turtle Island and recognizes its place in the creation story.

### 3.1.5 Value of Bimaadiziwin 'Thinking' as a Cultural Concept

Culture refers to integrated components of human behavior traits that include the language, thoughts, communications, actions, and customs (Cultural Competence, 2014; Watt, Abbott, and Reath, 2016). Thus, placing Bimaadiziwin into a cultural context of thinking is the required transition that was historically omitted. Now, it is essential to restore that connection to better serve its purpose for the people.

A. Irving Hallowell, a noted social philosopher of the 1950s, contributed some of the most revolutionary ways of thinking, best written when he was presenting his work in behavioral observations with the Anishinaabe (Ojibwe ontology) identity culture and

Rorschach ink blots analyses (1976). His research introduced cultural traits and cultural values consistent with the contemporary idea that Ojibwe viewed human life and non-human as animate. Hallowell's position rested on real experiences of persons in a behavioral environment and not with constructing a theory of the real (Hallowell, 1975) "All cultures provide a cognitive orientation toward a world in which man is compelled to act. A culturally constituted world view projects available knowledge and language, mediates personal adjustment to the world through such psychological processes as perceiving, recognizing, conceiving, judging, and reasoning which intimately associated with normative orientation, becomes the basis for reflection, decision, and action and a foundation provided for a consensus with respect to goals and values" (in Kelly 2003, p. 36). However, to fully comprehend the Anishinaabe thinking system, an individual must experience their self as being within anishaa naabe, or first man. This change design in thinking leads with intent to improve longstanding psychosocial, behavioral changes, rather than intermittent coping (Kelly, 2014). That distinction is one of many indigenous psychosocial determinants that strengthen the value of incorporating the Cultural Specific Approach for the Anishinaabe and any community of people for that reason.

### 3.1.6 The Meaning of "Anishinaabe"

The Anishinaabe is proud and humbled by his origin: proud that he is integral to the creation, humbled that he is dependent on it, and yet loved by all spirits (Kelly, 2014, p. 24). The origin of the word Anishinaabe is a self-revelation and has two meanings: The contextual meaning of Anishinaabe comes from two linguistic parts and means, "man

descended." The second meaning derives from a humility perspective, and this notion of humbleness is observed in select forms of Anishinaabe language and action.

### 3.1.7 The Seven Grandfather Teachings

The Anishinaabe observe seven fundamental laws of creation to build upon his relationship with all other life: love, kindness, sharing, respect, truth, courage, and humility (Benton-Benai, 1979). During daily life, the Anishinaabe sought to follow the meaning of these laws and came to understand that these laws were symbolically key to life through the Sacred Four principle teachings that had touched him during his descent (Kelly, 2014). The seven teachings of Bimaadiziwin are interpreted through the good life for the Anishinaabe and are the cornerstone of the Cultural Specific Approach for the Anishinaabe.

### 3.1.8 The Language, Gifts of the Creator

Language is one's identity. Language is the primary means by which culture is transmitted from generation to generation. The very meaning of world views and traditional lifeways are understandable in their original languages. The origin, the history, the peoples' relationship to the spiritual world, and the land are in the language. The totality of social, cultural, economic, and political systems of Indigenous nations is also in their native languages. The cultural nuances and intricacies of Indigenous constitutions, laws, and governance structures must be explained and understood in the language of origin. A language is an inviolable gift to the Indigenous peoples from the Creator and their ancestors (Kelly 2014).

### 3.1.9 Value of Bimaadiziwin as a ‘Living Philosophy'

Mino Bimaadiziwin and its corresponding teachings affect the current manifestations of Cultural Specific Approach that instilled rigor in the continued practice of traditional medicine and fashioned the theoretical environment within which Bimaadiziwin operationalized. In this review, the rest of the first chapter on Bimaadiziwin background explains the framework of the cultural ideology of the practitioner-patient medication therapy interactions in rural clinics on Anishinaabe reservations.

## 3.2 Section Two: Bimaadiziwin and Reservation Life

### 3.2.1 Relationship of Spiritual Advisor and Traditional Healer

This second area of review addresses the literature that focuses on the influence of spiritual advisors and traditional healers to optimize the medication experience. Spiritual advisors and traditional healers are an integral part of the native worldview. Their influence and advisement extend to all areas within the life pathway (and death) for native people. There are noted differences between the terms spiritual advisor and healer depending on the context of knowledge requested, but the main point is that the native people always knew there was help and an explanation for them when they needed it. There are many cases today where native people employ the practices of a traditional healer for healing, instead of going to clinics or hospitals, preferring the comfort of their (native) teachings. Historically, it has been less than a few decades of the westernized medicinal approach that has made a deliberate change in how the medication experienced is viewed for native people. Within the Anishinaabe tribal lands today, there is an overall restoration to learn the teachings as once experienced from those elders who have had first-hand accounts of

witnessing the foremost authority and value of traditional healing practices consistent with tenets of Bimaadiziwin.

> *Personal reconciliation is making peace with one's own self and reclaiming one's identity. Through the kindness of the Creator, I am at peace with myself. I have returned to Midewewin, the principal spirituality of the Anishinaabe. I have come to understand and respect the interconnectedness of all life, and I am very happy with my place in creation, humble as it is. Mine are the gifts of life so sacredly conferred upon my ancestors by the Creator. Through this spirituality, mine also is the experiences that have rendered insights into life's eternal questions: whence, what, whither, and why.*
>
> ~Fred Kelly 2014, Ojibwe
> traditional elder and Ogema

Within the Anishinaabe tribes in Minnesota and Wisconsin, few chapters reference deal directly with the implications of Bimaadiziwin as a health belief model or have absorbed the precepts of Bimaadiziwin in developing a working relationship with practitioners and clients. As with most Anishinaabe clients, acknowledging their cultural heritage and spiritual beliefs as necessary functions have been the duty of the traditional healers or spiritual people; however, there are vastly fewer responses from the passing generation of Anishinaabe elders able to authentically employ medication treatment benefits, and thus, vital knowledge is lost. For example, during the time of early statehood of Minnesota and Wisconsin, there were far greater numbers of Anishinaabe people who were competent with advanced treatments with medicinal plants (Hennepin 1880:284 in Vecsey 1983, p 154) and broadly practiced healthy living (Long, 1791). In retrospect, historians and medical ethnographers randomly collected journals of acquired native

pharmacopeia (Blessing, 1977). Although their writings were plainly ignorant or complacent of native tribal practices (Landes, 1937), their writings preserved nuances of colonized interpretation. In many instances, the quality of ethnopharmacopeia was taken out of the contextual environment of cultural beliefs and Bimaadiziwin standard practice (Baraga, 1976; Catlin, 1841; Wan et al., 2007; Whitbeck, Sittner-Hartshorn, and Walls, 2014).

### 3.2.2 Pharmacopeia: Long-lasting Influence as a Westernized Approach

In this section of the literature review, it is worthwhile to revisit the importance of the early pharmacists' work before the 1900s that systemically generated the primary sources of Pharmacopeia (Blessing 1977; Densmore, 1979), cultural exchange and also preserved some of the earliest contributions of pharmacist-patient relationships (Vecsey, 1983). Hence, by reviewing the records of early interactions of these accounts, the story of where Indian medicine collided with socialized Westernized approach appears and the start of health disparities begin, 564 years ago for the majority of Anishinaabe tribes as non-native civilization spread through their lands, changing the face of American Indian cultural identity forever. As history records the expansion of pioneering settlers' westward migration across the Great Lakes region, ancestral lands to the Anishinaabe people, they lamented empty fields explicitly long bereft of healing that were once considered gardens of plenty. The era of reservations had taken hold and the quality of life for the Anishinaabe had changed (Figure 7).

A resurgence of sociocultural consciousness and health-seeking motivation within the Dream Drum societies (Vecsey, 1983) emphasized curative importance. While not all

Anishinaabe were Midewiwin, in the early 1870s, as one of the prophesies fulfilled, the Dakota Indian people transported The Dream Dance to the Anishinaabe territory. The healing stories of Tailfeather Woman and the gift of the Dream Drum bound ties between Indian nations, the Anishinaabe of the Mille Lacs region in Minnesota were spiritually blessed and healed. Generations later, in 2009 the families and descendants of the Santee Sioux Dakota nation and the Ojibwe of Mille Lacs Band once again, reaffirmed their pledge between nations (Morales, 2009; St. Germaine, 2009). In this living docu-history of peace-keeping, the power of women and their profound knowledge and relationship of healing (keepers of life, medicines, and therapies) highlighted the ceremonial event (St. Germaine, 2009). Throughout history in the northern region of Minnesota and Wisconsin, native communities kept natural stores of medicines from plants for curative therapy. The integration of western contact attributed to the influx of many diseases the native people had not witnessed before (Baraga, 1976). Their experiences with westernized medication had now begun.

While medication discovery continually changes in current medication therapies, there also exists a growing number of patients who demand alternatives to prescribed medicines. Utilizing native knowledge of medicines for Indians was not a new alternative. These medicines always were their mainstay. Their complementary health approaches, noting the Americans' use of natural products and the use of mind-body approaches (Haynes, Hilbers, Kivkko and Ratnavyuha, 2007), have recently emerged to foster new health directives, rekindling a complementary approach to integrative and psychosocial elements (Wan et al., 2007). Expansion of holistic medicine approaches and alternative

plant medicines stimulate resourcefulness to understand the present integrative demand (Shanley and Luz, 2003) toward specialized medicines (Bassett, Tsosie, and Nannauck, (2012). Strengthening the psychosocial determinants of health behaviors through health literacy in a desired program of pharmacy practice (Jacobson, Gazmarian, Kripalani, McMorris, Blake, and Brach, 2007) includes the formation of unique Cultural Specific Approach models from each tribe.

### 3.2.3 Acculturation Theory and the Impact on Cultural Specific Approach Competencies

Acculturation is the phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the cultural patterns of either or both groups (Herskovits, 1937; Vogt, 1957). Given the impact of acculturation theory (Vecsey 1983; Tanenbaum, Commissariat, Kupperman, Baek, and Gonzalez, 2013) towards the Anishinaabe people and their health belief system, the evidence submits the loss of traditional religion, threatened to extinction, was due to government laws forcing compliance with Western "civilized" living. In its place, sporadic vestiges of the original belief appear only in certain localities.

Vecsey (1983) describes the detrimental losses that affected the overall living conditions of the Anishinaabe people in substantial capacity i.e., health, subsistence, social organization, and leadership, because it was derived from a zealous perspective with the arrival of the White man. Through time, Western society imparted idioms of health standards alienating the Anishinaabeg from participating in their own health beliefs

through historically deregulated and classified non-negotiated health policy reformation (see Figure 8. *Timeline of cultural profiles among American Indian Indigenous Cohort Experiences*, 1883 Indian Religious Crimes Code) that discriminated against essential matters of indigenous health belief. Without their health belief, the Anishinaabe was, as Vecsey conveys, "lost." In retrospect, the coming of the Europeans brought forth a foreign concept of disease and ill health. This created a distinct germ theory that culminated with the demise of whole native populations and proved resistant to Indian cures.

Figure 8. Timeline of Cultural Profiles among American Indian Cohort Experiences

| ERA | 1300-1800 | 1900-1920 | 1930-1940 | 1950-1960 | 1970-1980 | 1990 | 2000 |
|---|---|---|---|---|---|---|---|
| **World** | USA delivers Historical Trauma & Treaties, Reservation[1] | Loss of Reservation Lands; World War I | World War II; Atom<br>The Great Depression | Viet Nam War; generational challenges begin[16] | Apple Computer & Cell Phones; Pol Pot; Nuclear storage[24] on reservations | Desert Storm; Race Wars and Other Race Relations | 2007 UN: US denies support of Indigenous Peoples;[38] Bin Laden;<br>NDAPL |
| **Dated events** | 1492 Mass Genocide, Disease Warfare; 1640s Wall Street 1711 Slavery | 1924 Granted Citizenship; Loss of Land by Taxation and Cultural & Language Barriers[5] | Boarding Schools;<br>Churches;[9]<br>Removal of Children[10] | Relocation by BIA and BIA schools to Urban Areas;[17] IHS[18]<br>Steel Workers; Trades | Indian Education & Activism[25]<br>1975 Self – Determination Act; 1972 National Indian Health Board[26] | Litigation; Scientific and Medical Experiments on vulnerable pops. cease[30]<br>IRB | 2016 UN: 44th Pres. Obama Declaration on Rights of Indigenous Peoples (UNDRIP) |
| **Outcome Event** | Expansion of Western Medicine[2] Frontierism; Treaties; 1824 Bureau of Indian Affairs est. | Forced Removal from Families & Ancestral Homes[6]<br>Boarding Schools[7] | Loss of Land and Securities, Identity within Tribal Acquisition;<br>Tribal Councils[11] | 1965 Bureau of Indian Ed. Act: Elementary and Secondary Education Act;<br>CFR[19] | DHHS & Social Programming;<br>Treatment Centers;<br>NCAI, NIEA, | Self-Determination of Tribes;[31] Indian Gaming<br>Per Capita Stratification Higher Ed. | Boards & Committees;<br>Research,[39] Technology<br>Post-Doctoral Education |
| **Determinant** | "Save the Man, Kill the Indian,"[3] Not Human, | Cultural Traditions Banned,[8] | Forced Assimilation; Prohibited Cultural Living[12] | Forced Education Praxis; Denounced culture[20] | Exploited workers[27] Disadvantaged students; Elder loss | Capital Increase for some tribes;[32]<br>Medicine[33]& Research[34] | SES,[40] New Terminology; Inclusion criteria;[41] Health stat[42] Data Mining |
| **Societal Effect** | Forced Removal to Reservations 1883[4]<br>No return to Original Habitation | Spiritual Practices Banned[9] & Physical Mistreatment<br>Tribal Loss | Boarding Schools;<br>Blood Quantum[13]<br>Family Loss[14,15] | Loss of teachings;[21] Undervalued culture: Language Loss[22] Elder Loss[23] | Tribal Constitution[28]<br>Powwows<br>Childhood Loss[29] | Reservation Gaming;[35] Revitalization of teachings[36] Technology; Cultural Practices[37] | Revitalization & Restoring Language[43] Traumatic Events[44] Addressed; Elder Loss;[45]<br>End of ERA |
| **Age** | deceased | 90s – 80s War Era | 70 – 60s Elderly | 50 – 40s Baby Boom | 30 – late 20s Young adults | 20 yr olds "Gen X" | Teens, <10 Adolescents |

Some events are common knowledge and not cited in this table. Citations are categorized in columns by ERA: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Father Hennepin in the mid-seventeenth century (1880, in Vecsey, 1983 p. 154) conveys "they know roots and herbs with which they cure all kinds of diseases, they have sure remedies against the poison of toads, snakes, and other animals, but have none against small pox." In that short narrative, the Anishinaabe were confused by the belief in the Manidoog and the traditional understandings of known diseases that now left them destitute. Facing new diseases unknown to their families and healers, their prayers

provided no answer, no meaning. With increasingly more white settlers appearing in the northern regions of the Midwest, there were severe epidemics of measles, tuberculosis, and other white diseases states such as scarlet fever, cholera, and the flu, against which the native Anishinaabeg had no immunity. The result left the Indian villages at a crux in their religious moorings of cultural and spiritual health beliefs. Epidemics were recorded along the Lake Superior region from 1781 – 1782, and 1846 (Mc Donald 1929 in Vecsey, 1983 p. 154); and in Minnesota and Wisconsin from 1882 – 1883 (Fred Smith to Whipple, 20 September 1882, S.I.R. McMillan to Whipple, 1 February 1883 in Whipple 1833-1994, Box 16 in Vecsey, 1983 p. 154). Sources retell stories yet today about the prevalent diseases caused by association with white farmers and how the Indians had to boil their clothing and use poultices to draw out deadly bacteria (St. Germaine, personal communication Oct 12th, 2016). On the Lac Courte Oreilles reservation in northern Wisconsin, school children in the original Kinnamon school were vastly affected by the flu during 1918-1919, and had nowhere else to turn for help, except for the local Catholic school nuns who braved the cold and poorly habited school buildings (St. Germaine, personal communication Oct 12th, 2016). Coincidentally, the Anishinaabe families blamed themselves for their individual failings as their sacrifices to the manidoogs were not enough to stem the power of the white man (see Figure 1). The medicine people were powerless against the diseases of the white man, and they did not know who or how to help. The medicine people remembered the old prophecies that were made manifest to them and through prayers, the next chapter of life with the white people began.

While the Anishinaabe persisted in adherence to their medicines and healing

traditions, they knew interventions had to be made, and in addition to their knowledge of the plant-life of the woods, they needed the medicines to fight disease. This interaction with the white people had to be the start of a new integrated health belief model. Much as today, the Cultural Specific Approach is based on the very same historic premise of long ago; it just had to be revisited. Bimaadiziwin has not changed, and the same circumstances remain, much as they have since the early 1900s.

During the late 1880s, among those Indian families who were physically able, some turned their back on the federal government rations, land allotment, and the "good Christianized life" that was promised and returned to live hidden within the safety of the woodland forests (Johnson-Anderson, 1967, personal communication; Flocken, 2013). These families deeply believed in an unfathomable spiritual realm (Figure 1) and, though they knew they were venturing on the frontiers of change, they carried their souls in their prayers above, and trusted in their minds the value of skilled hands that for thousands of years practiced cultivating and gathering of *manidoojiibik,* medicines. Though it was difficult, those families survived (Johnson-Anderson, personal communication, 1982; Sutton, personal communication, 1976; Ritzenthaler, 1945).These original native medicines and formulations in their recitation form still survive today, written down in 1939 for lung ailments, tuberculosis, and female back illness, eshpin a'aow asaabikeshi (Niizhoogawbowikwe, indoonjibaa Odaawaazaaga'iganing minawaa Nokomis; Johnson-Quaderer, personal communication, the 1970s; Densmore, 1979). These life accounts provide evidence for the inclusion of the Cultural Specific Approach that represents a sustained record of medicine and knowledge among Anishinaabe people.

Decades of categorical influences and events shaped the broad framework of social determinants affecting American Indians. Without evaluating the numerous events, the major causes still produce ill-content toward westernized health initiatives even though the outcomes of medicine have progressed. However, analyzing the respective gaps within the contemporary health initiatives through the continuous decades are revealing of the age groups that experienced life through war, relocation, and loss of ethnic identity within their own country. When visiting with patients older than 60 years, the stories they recall from their own experiences and those of their parents are vastly different from the perceptions of a younger generation. Grasping the challenges of how to effectively gain the trust of these patients and respondents within a survey are two of the most significant dilemmas presented to researchers. Utilizing an EIM from information in historical profiles (Figure 8) may help in devising better questions to respond to their recollections of the way their earlier lives were depicted and may present valid references of the cultural profiles' characteristic to those age groups. For example, understanding the perceptions of prescribed drug therapies within an older generation given their experiences of non-accessible healthcare and mistrust of physicians and research initiatives are conducive to promotion of the theory of a culturally specific approach to health that is formed from the variables of known characteristics of a native community.

Present trends of evidentiary-based treatments (EBT) for native research (Walker, Whitener, Trupin, and Migliarini, 2015) and community based research (CBPR) integrity (Southam-Gerow and McLeod, 2013) are reviewed in the wealth of literature that focuses on psychosocial determinants (Hall, 1976) of health belief models (Wan et al., 2007). They maximize internal strengths of sociocultural beliefs (Duran and Duran, 1995), cultural

competence frameworks (Whitbeck, McMorris, Hoyt, Stubben, and LaFromboise, 2002; Sue, Zane, Nagayama Hall, and Berger, 2009), and adherence and compliance with Westernized viewpoints of medication therapies (Hallowell, 1976; Jung, 1963). Moreover, while most models of Westernized medication therapy focus on provider level of treatment modalities, the emphasis of content (i.e., Bimaadiziwin health belief, Midewiwin, tribal rites, and all other religious practices) is neglected, or usually relegated to behavioral theorists. Therefore, Bimaadiziwin, the most crucial concept identified in this study, highlights a change in basic assumptions in understanding Anishinaabe patient health. It describes a new conceptual model (Figure 1) that more accurately describes the historical, but relevant health belief of the Anishinaabe people with its practical features and seeks to amend the current cultural misconceptions of tribal identity correlated with the needs of patient health.

This review of literature now turns to the current trend of provider-level versus systems level of treatment (Cipolle, Strand, and Morley, 2012) utilizing an ethnographic interpretation to determine for the first time the results of the tribal information. Current practices (Vecsey, 1983; Whitbeck, Sittner-Hartshorn, and Walls, 2014) reflecting historic Anishinaabe health belief (Hallowell, 1975; Long, 1791), though scant, still appear to be misunderstood and contribute more to the gap in all literature resources.

### 3.3 Section Three: Nomothetic Methods to Explain Bimaadiziwin

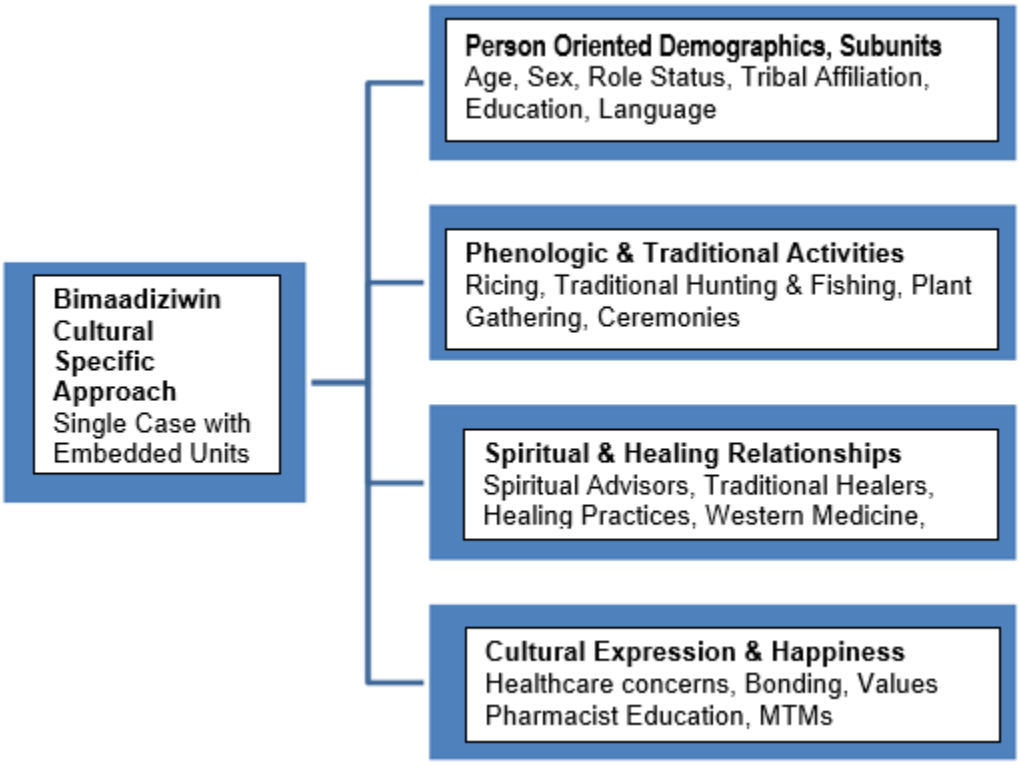
The third part of the literature review concentrates on the merit and critique (Bowling, 2002) of the nomothetic method (Diener and Fujita, 1995) that was chosen to

explain the Cultural Specific Approach. Nichols (2011) explains that Nomothetic research methods attempt to establish general laws, patterns of behavior across a population of individuals and generalizations from group level patterns. The nomothetic methods use data in all forms, quantitative and qualitative, from all group members (i.e., relative ranking) to determine the relationship between variables across individuals.

### 3.3.1 Conceptual Framework of the Nomothetic Approach and the Cultural Health Belief Model

The purpose of the nomothetic approach is to obtain objective knowledge through scientific methods (Figure 9). Hence, quantitative methods of investigation are often utilized to produce statistically significant results. The consequent laws that are formed can be categorized into three kinds: classifying people, establishing principles and establishing dimensions. Qualitative methods are beneficial in extending a statistically narrow case to a broader, higher significant finding, theory building, analytical generalization (Yin, 2014. p. 68). An example of the mixed methods of quantitative and qualitative analyses from the realm of psychology is found in the 'Diagnostic and Statistical Manuals of Mental Disorders' (DSM), which provides the classifications for mental illness, classifying people in group membership.

Figure 9. Conceptual Framework of Variation within a Nomothetic Span with Embedded Units




Case study of Cultural Specific Approach: Bimaadiziwin and embedded designs (Level One) data from case studies that are analyzed within subunits separately, between different subunits (between case analyses), and across all of the subunits (comprehensive Cultural Specific Approach model). Case analysis of the component units is analyzed through categorical aggregation and direct interpretation. Use of convergence analysis binds the qualitative methods to present a single case phenomenon to Level Two representing the theory stage.

The course of action of investigation used by the nomothetic approach collects scientific, interpretative qualitative and quantitative data. All data from experiments and observations are used, and group averages are statistically analyzed to create predictions about people's behavior. Responses are analyzed for variation around the group mean and then averaged to get a common index, or correlation coefficient, *r.* This correlation yields

a ‘between-person’ pattern and is intended to apply to all individuals across the group.

A scientific example of this behavioral approach demonstrates Milgrim’s experiments on the Laws of Obedience (Nichols, 2011). From the data generated through his scientific experiments, Milgrim discovered that 65% of his participants would harm another person, (via a 450v electric shock) potentially killing them, due to instructions when given from and within the presence of an authority figure. Although there were many ethical issues with his experiment including the deception involved and potential harm to the participant, this is an existential example of nomothetic research that largely magnifies how the authoritarian, consequential traumatic history of the American Indian evolved before racial justice reform. Milgrim contributed to the Laws of Obedience by repeating his experiments many times over.

The nomothetic approach is considered broadly scientific due to its precise measurement, prediction, and control of behavior, investigations of populations or large groups, objective and controlled methods allowing for replication and generalization. Due to these investigations, nomothetic research helped the study of psychology gain more scientific robustness by developing theories that can empirically test variables, which is one of the key criteria of science.

However, the nomothetic approach has limitations. Nichols argues the nomothetic approach can be accused of losing sight of the ‘whole person,' due to its widespread use of group averages. Nichols (2011) further explains the nomothetic approach also may offer a superficial understanding of their explicit behaviors, as people may display the same behavior, but with different explanations.

Here, the available literature expands reasoning on the sociological (Duran and Duran, 1995; Ehlers, Gizer, Gilder, Ellingson, and Yehuda, 2013), behavioral (Jung, 1933; Gustafson, 1997), and psychological validations (Hallowell, 1975), using the nomothetic ideology instead of an ideographic approach (Nichols, 2011). The nomothetic technique is most appropriate to address how American Indian spirituality and health belief are expressed and how it contributes to health and healing. Yet, these literary contributions have yet to be expressed in Anishinaabe perspectives (Lurie, 1980; Ferguson, 1996). Nomenclature and related best practices in cultural competency, designed to enhance patient perceptions of health and promote treatment effects, are explained in many theoretical models (Long, 1791). Except those study models are not justified for the Bimaadiziwin as an *a priori* construct. Fundamentally, the revision of methods contributes to clearing the misconceptions underlying the processes of health belief and attitudes toward medication therapy management principles. Future opportunities that combine health belief and redesign instruction in cultural attributes and participation for practitioners in medically underserved populations are emphasized as desired pharmaceutical education outcomes.

The nomothetic technique was used to obtain unbiased knowledge from rural reservation patients and survey participants. Unlike the ideographic approach, quantitative data, observations, and group averages will be analyzed to create prediction and control of behavior, investigating large groups of people, like the reservation populations, allowing for replication and generalization to future research and statistical results in the field of pharmacotherapy and pharmaceutical care. With this background to create and collect

scientific statistical data, these measurements will be validated to support the development of theory, such as Bimaadiziwin, and empirically tested, a key component affirming construct scientific analysis.

A drawback to the nomothetic approach is that it does not address individual factors as critical due to the use of group median averages. For instance, do we then lose sight of an individual patient's interpretive signs and symptoms of illness, and to what extent is this a significant limitation? Do the specific populations of reservation residents display the same behaviors but for distinct reasons? These questions could complicate or contribute to misclassification bias.

### 3.3.2 Application of the Nomothetic Approach to the Inclusion of Bimaadiziwin as the Cultural Specific Approach to Health Belief Theory

A nomothetic approach to this study explains effects that are unique to a population who, characteristically defined by their historical use of Bimaadiziwin principles, persist. It uses psychometric testing, experiments, and quantitative data from group studies with correlation, making no distinction between explanatory or response variables, to construct a causal model. It helps develop theory. Contrary to group studies, an idiographic approach utilizes a compilation of personalized factors, individualized factors that designate each a unique variable, and not towards characterizing the whole population of subjects. Instead of proposing a blended model, the ideographic technique splinters the construct more than building the parts and tries to delineate and explain factors beyond which Bimaadiziwin never intended.

Proponents of qualitative research methods encourage viewpoints from an etic

point of view and attempt to describe and define spirituality among tribal populations. The evidence of historical phenomenology of Bimaadiziwin spiritual precepts is still not well understood, even though based on first-hand perceptions or subjective opinions of past anthropologists' traditional reference points (Flocken, 2013, p. 133-136; Shils, 1981; Benedict, 1923 p. 73). Moreover, while historical accounts offer a verifiable description of what anthropologists observed, the ability to quantify the evidence was still largely subjective based on their 'outsider' observations (Kegg and Nichols, 1991). It would have been fortuitous to venture to ask the participants what the meanings were if they had the chance during that period. For that reason, this study uses the nomothetic approach and uses oral teachings as a continuous, historic account of Bimaadiziwin as a living, theoretical construct. This study's premise examines Bimaadiziwin construct as an intrinsic value factor, meaning that the Bimaadiziwin Cultural Specific Approach embodies a factor that causes positive changes, that are evinced through the spiritual practices, and traditional activities bestowed from the Creator. These changes reflect joined-healing, belief practices, and iterations of the Original Peoples' statements reflective of their long-held beliefs.

Therefore, founded upon these definitions from the field of psychology research, the study of Bimaadiziwin fit the description for a nomothetic conceptual approach to normalizing spiritual and health domains as representing the characteristics of the Anishinaabe community.

### 3.3.3 Offerings of Cultural Specific Approach to Influence Behavioral Change

Bimaadiziwin is an overall way of life that exists to explain all the things that life has to offer for the Anishinaabe. If the Anishinaabe follows its teachings, the Anishinaabe

will have a good life, *mino Bimaadiziwin*. Philosophically, Bimaadiziwin is only for the Anishinaabe, and not for other tribes or non-Native persons. For example, the tribal nation of Dine´, or Navajo, respects tenets represented by the 'Beauty Way' (Manuelito, 2006). The Beauty Way is their most sacred life or Cultural Specific Approach. Again, the components of Cultural Specific Approach discussed in the literature for the Dine´ people, their foundational spiritual and Cultural Specific Approach, is not acknowledged *a priori*, nor is it brought forth as the first approach to treat illness, but it should be. More so, within cultural ceremonies and health practices, the Dine´ exceedingly respect the teachings of their spiritual, or medicine people. Further, many traditional practices involve gifts given as a blessing (medicine) and iterative instruction, which the Dine´ patient will readily recognize and adhere, and the outcomes of health teachings at that point are easily followed and accepted. Without the Beauty Way teachings, the Dine´ patient is left feeling unbalanced, neither 'whole' nor 'well' (Wyman, 1972).

Another example of the specificity of the cultural approach with other tribes is illustrated below. This story is from a tribal member of the Shoshone-Bannock Tribe (Bitsoi, 2012).

> *When Sunshine Perry, 19, was still in the womb, her pregnant mother fell in the bathtub, and an ultrasound confirmed that the baby had journeyed to the next world. But her father, Dude Perry, refused to listen to the doctor's diagnosis. Instead, he turned to a traditional Shòshone-Bannock sweat-lodge ceremony and conducted a prayer for his unborn child and wife, Shirley Keeswood.*
>
> *"When we finished we went back to the hospital and told the doctor to run another ultrasound on her to see," Dude said, adding that the doctor refused and instead wanted to flush out the mother's*

*womb to avert the threat of infection from a dead fetus.*

*"I told him no and said we just had a ceremony for her, and I told the doctor, 'If cost is a problem I'll write you a check right now. Do it again,'" Dude said. "And so, they did it. As soon as they put that machine on her, they picked up her heartbeat and it started really going."*

*To properly honor this blessing, and in keeping with traditional Shoshone-Bannock custom, Dude went down to the river - Down Bottoms - to bathe and meditate on a name for his daughter.*

*"In our belief, when a baby is born we go into the water and we pray," Dude said. "When I was sitting in the water, the sun was hitting on me.*

*It made me feel warm. That is where 'Sunshine' came from, and 'Woman With Two Lives' (her middle name). The way I see it, she's on her second life." Asked how she felt about the story, Perry replied, "It was crazy but that showed how much we believe in our culture and sweat and spirituality. It's a real good story. I like it. My dad told me about it."*

## 3.4 Section Four: Conceptual Framework

If we recognize the tribal people on reservations have faced an unfavorable generational decline in health and wellness since colonization, an epistemological and design shift is needed to reinvigorate keystone teachings that have been the sustaining foundation for millennia and to establish the model of Cultural Specific Approach in all references to the American Indian.

Thus, a critical but explanatory theory becomes compulsory to support the inclusion and *a priori loci*, or antecedent position of the Cultural Specific Approach that is attained by the Nomothetic Approach (Wright, 2008). The Nomothetic Approach introduces a systematic explanation of the underlying phenomena, such as describing the overall

precepts of the Bimaadiziwin Spiritual and cultural traditions for Anishinaabe tribal reservation residents. While the Nomothetic Approach does not dwell on individualistic similarities or differences, it captures the combining factors, multiple truths, that describe the population parameters as a whole, sometimes described as holistic theory. This explanatory research governs various aspects of psychosocial and spiritual reality for a group or cohort of people and is outlined by an ethnographic style of research within qualitative social science methodology (Cross, 2001).

Nomothetic [Gk.] means 'proposition of the law' and was made prominent in 1937 by Dr. Gordon Allport, an American psychologist at Harvard studying classes of people and going beyond descriptions of over 18,000 traits of personality, which still did not satisfy all variations of behavior. His observational studies on intrinsic and extrinsic traits sought to explain their behaviors of character traits as a group; rather, than the individual behaviors and psychoanalyses (Allport, 1962).

Nomothetic describes the study of classes or cohorts of individuals. The subject is seen as an exemplar of a population and their corresponding personality traits and behaviors. These behaviors contribute to a vast, archetype of empirical evidence, a paradigm often immeasurable within a mainstream intersection of 'Western culture' (Adams and Strother-Adams, 2001), and even less so characterizing the duality of native beliefs reflecting cultural identity of a tribal nation. (Figure 8).

The nomothetic technique contributes four distinctions in its approach: observational, causal, causality, and probabilistic.

The Nomothetic Approach is an observational method to knowledge. It allows for

the creation of theories where there has not been much previous research. Nomothetic Approach explains how the Cultural Specific Approach, Bimaadiziwin, is both explanatory and value-laden at the same time (Humphreys, 2012).

The Nomothetic Approach is defined as a causal relationship that is assumed to happen among many cases (people) in addition to "non-living" entities, or non-people. It answers the question, 'why' (Wright, 2008). The examples which come to mind are the standard deontic logic (SDL) schema, or 'ought' permissible, or omissible, conditional statements of the Bimaadiziwin cultural health belief. Bimaadiziwin is a key axiom present in ontological modal logics and tells us that if a material conditional is obligatory and its antecedent is obligatory, then so is its consequent (McNamara, 2014). For example, if the patient self-identifies as Anishinaabe, the Bimaadiziwin understanding of life and living is certain to have an obligatory effect on whether the patient adheres to the advice given from either a traditional healer or practitioner in western medicine. This modest example expresses a sagacious principle within many Anishinaabe communities, particularly at seasonal periods to those individuals practicing and receiving instructions about their personal healing within the Midewiwin Grand Medicine Lodge.

The next distinction of Nomothetic Approach is causality, normalizing assumptions whether a cause happens every single time or just some of the time. The Nomothetic Approach refines the effect of the predictor variables that determine causation and results in an outcome that is generalizable to understanding the values of the whole community. For example, the approach may exemplify professional pharmaceutical care practice activities respective to an indigenous community's cultural mode of behavior and

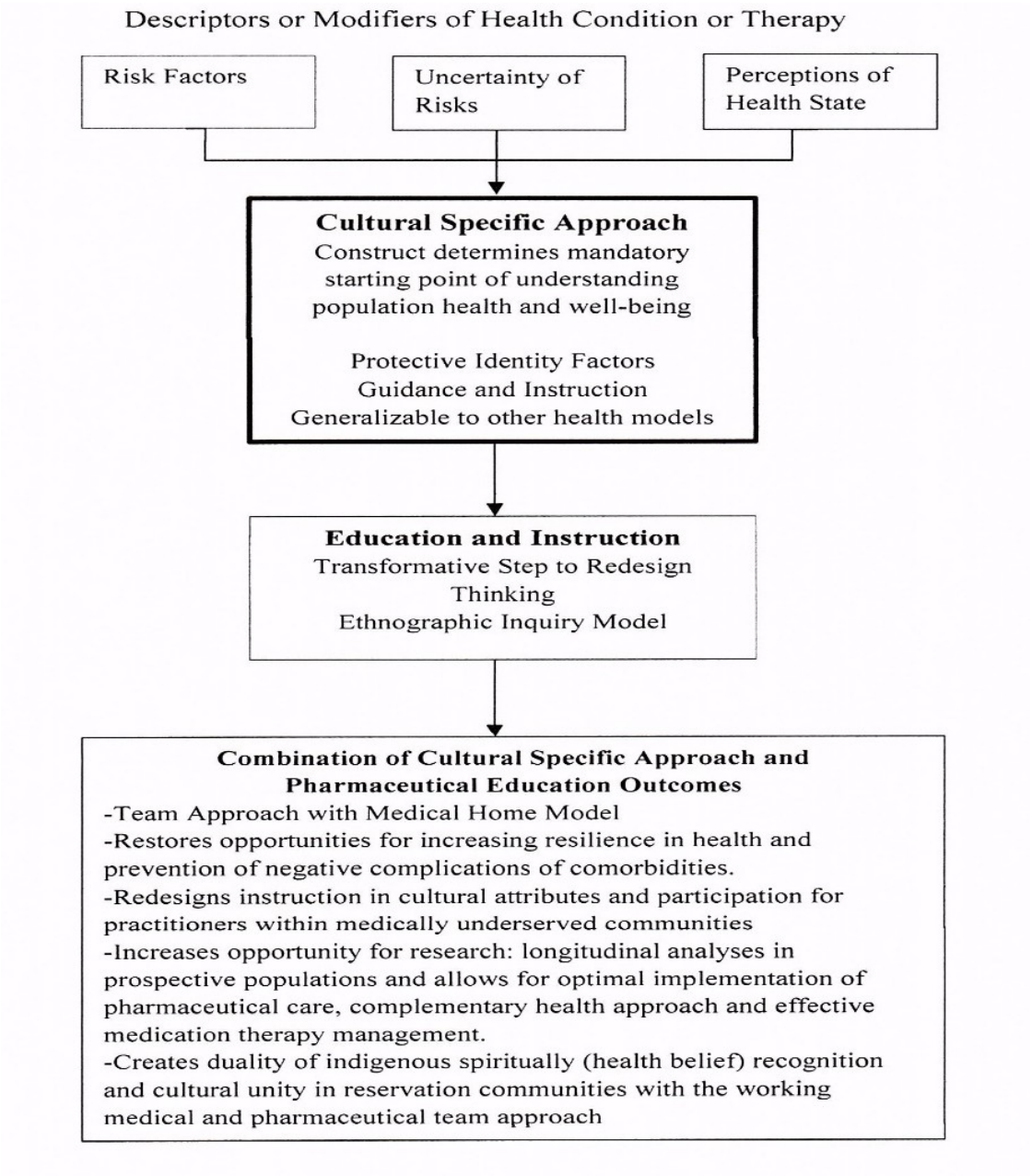
reasoning; while not separating the two domains, presents them with a clear, refined, but culturally skilled approach.

Nomothetic explanations are probabilistic, not deterministic, and make use of generalizations across dependent variables versus specific, individual properties. This technique is rational and takes into consideration the variability of factors characteristic of population health.

### 3.4.1 Rationale for Incorporating the Nomothetic Approach and the Cultural Specific Approach to Health Model

The rationale for incorporating the Nomothetic Approach was to find a conceptual method that allowed the study to gather evidence from existing data and interpret the findings in ways that best reflect the representative health belief for the Anishinaabe people. This representation of the *a priori* Cultural Specific Approach model builds upon existing frameworks and can now be evaluated for its strengths or weaknesses; however, as each piece of data converges in the analytical process, it serves to logically contribute to the researcher's understanding of the whole picture. (Figure 10).

Figure 10. Evaluation of the Cultural Specific Approach Model to Health




The *a priori* specification of the Cultural Specific Approach construct permits the initial design-thinking of a theory-building study. As the Cultural Specific Approach

construct guides new sequential processes of theoretical actions, better information from the data can be gleaned using a justified model. From this convergence of data and interpretation of findings, rigor is established with an organized database and allows researchers to measure construct validity more accurately. As the study progresses, this opportunity to develop the evidence that has been eluding most community-style research and establishes its importance. This gives the researcher a firmer empirical grounding for support of the emergent theory that describes the current state of health data opportunities for tribal nations and all other healthcare organizations.

Working past the rigor, the central theory of the Cultural Specific Approach serves to qualitatively explain social behavior (grassroots organizations that step in to save lives), illustrate events (addiction, intent to enter treatment) and describe the Bimaadiziwin phenomenon (energy to heal, stepping out of comfort zones, changed, or transformed lives). These are the findings of the hallmarks of a theory that is composed of constructs (concepts) and the relationships between those constructs (propositions) that collectively present a systematic, logical, and coherent explanation of a phenomenon of interest (Bacharach, 1989). Most importantly, however, the researcher must learn from community experts ahead of time to get a sense of propriety of the cultural specificity with reference to prior literature, if available before formulating propositions—the "why" of case study research in qualitative explanatory methods. Nevertheless, it remains crucial to limit preconceptions about the community under study and relationships between variables since most of those outcomes are highly specious and most community members can spot those inaccuracies firsthand.

### 3.4.2 Theory Building

This dissertation study presents the *a priori* Cultural Specific Approach theory to health modeling, but more importantly, the theory commits itself to a proactive approach to understanding various relationships in healthcare. It seeks to provide an explanatory basis of the socio- determinants, characteristic of a population or community. The Cultural Specific Approach model is a value-laden process that uses theoretical concepts committed to spiritual and social identity, health, and wellness. Understanding that while the Cultural Specific Approach model is generalizable in its applicability, the model is not a neutral approach. It sifts through variables that do not correlate with the *a priori* foundational construct, and thus leads to a more precise framework in which to conduct research.

Five areas are important to consider with theory building: Precision, parsimony, perspicuity, replicability, and falsifiability (Bacharach, 1989).

Precision is foundational to theory-building research. Important theoretical concepts are developed and defined from the selection of cases of interest. Case studies are generalizable to theoretical propositions (analytic generalizations) and the detailsrevealed in the literature search underscore the precision of interpretation and aggregation. That is, using multiple sources or items of evidence to build construct measures, also termed triangulation. Tribes can adopt similar definitions, premise, and incorporate their own tribal culturally specific approach utilized in the Nomothetic method, understanding that the rationale functions in reciprocal, and comprehensive manner - data to theory approach and theory to data approach.

Parsimony is paramount to getting to the root cause of model inadequacies. Parsimony contributes to a focused research study even with vast amounts of data collected. In a prior review of the literature with American Indians as the focus, the conservative conclusions were considered weak and had almost no attention to reducing disparities (Brach and Fraserirector, 2000). Brach and Fraserirector (2000) assert the literature did not and could not link cultural competencies with the activities known within a diverse community. The Cultural Specific Approach simplifies the only reasonable explanation of who tribal residents are, what they believe, and how they interpret their health beliefs from the start. Most authors conceded they did not have access to actual dialogue with American Indians who live on reservations, and no literature reviews iterated any comment about their health beliefs, specifically in the Midwest region of the United States (St. Germaine, 2014). In certain case studies, while there were assumptions made, authors suggested various concepts and vaguely-worded relationships that described clinical non-adherence to medication but none applicable or acceptable to the patient (tribal member or other) without the inclusion of a responsible dialogue with the patient. This scientific concept of parsimony is also vital to protecting the indigenous ideology of health and well-being and upholding the respect of the cultural aspect of tribal residents' spiritual health belief.

Perspicuity does not depend on a single individual but describes discrete parameters, or variances within the Cultural Specific Approach in logical consistency relative to its people, events, and healthcare situations on the reservation. After the study is introduced with this dissertation thesis, further hypothesis testing and fitting of the Cultural Specific Approach model will extend understanding of the changes in healthcare

approach. The reasons further testing is needed are indicators may vary across cases and new (or justified) emergent relationships between constructs fit with the evidence in each case and each domain requires careful construction of definitions and measurable constructs.

Replicability allows the researcher opportunities to test the theory. It is advantageous to use the Cultural Specific Approach as much as possible as improvements to subsequent models may follow. The Cultural Specific Approach can be tested and retested because of the logical pathways that describe and define certain domains and truths of the concept.

Falsifiability, the theoretical propositions supporting the Cultural Specific Approach, can be disproven based on the same test and retesting empirical evidence. In as much as various approaches propose a gain or predict a positive position in a research problem, there has to be an opposing viewpoint, disposition, or alternative hypothesis that keeps the possibilities of scientific growth current. In this study, while the premise of the Cultural Specific Approach asserts Bimaadiziwin is a trait understood by Anishinaabeg, there may be the one individual who does not recognize that Bimaadiziwin trait of understanding within their Anishinaabe identity. It merely takes one probabilistic instance that validates the reasonable ideas of logic as applied to theory. This makes the Cultural Specific Approach theory falsifiable. The value of falsifiability is understanding there may be another reason behind an assumption, no matter the prediction. As the possibilities emerge to test the Cultural Specific Approach model in other areas of healthcare, this measure of reasoning is crucial to further comprehension of factors that are important to

clients and patients.

### 3.4.3 Rationale for the Single Case Study Design

The primary rationale for the single case study focuses on establishing the theory of Cultural Specific Approach as an *a priori* construct. This critical case has a set of precise circumstances which are assumed to be accurate and relevant (Figure 8.) Yin (2014) describes the rationales for a case study design that provide the background for building the theoretical model for this study. The second rationale for a single case study is the unique construct position that ultimately guides the next steps in the theoretical model and may change outcomes in testing the assumptions. The third rationale for a single case study is the common cause. The common cause is most relevant to the Cultural Specific Approach model because it captures the everyday norms of the community and perceptions that guide the best practices of the patient-provider relationship. The fourth rationale for the single case study design is the revelatory case. The revelatory case captures the opportunities for the researcher to observe and analyze the phenomenon at the heart of the study.

In this single case unit finding, Bimaadiziwin was both expressed in action, feelings, recollections, and pursued in daily life. The fifth rationale for a single case study design is the longitudinal case. The longitudinal case permits studying numerous variations of the single phenomenon, cultural health belief (Bimaadiziwin) at all levels of integration in the patients' daily lives. These actions were observed as embedded units and supported the validity of the propositions and invoked the theoretical analytic generalization, the Cultural Specific Approach Theory.

## 3.5 Section Five: Integrative Roles of the Practitioner

The last part of the literature review describes a professional perspective on integrating tribal cultural health care beliefs to strengthen present health care practices and significantly, improve the areas where health care is lacking. There is a vast need in rural reservation communities to foster new alliances with the health care teams and also to redefine health policies to serve the community better. Bimaadiziwin, the Cultural Specific Approach of the Anishinaabe has implicitly strong tribal teachings which can offer new strategies that are culturally congruent to most health policies. Those policies enacted on tribal reservations whether by the health advisory boards or tribal government are geared toward service within the population.

### 3.5.1 Role of the Pharmacist and Patient-Centered Outcomes on Rural Reservation Communities

The best aspect of elucidating the Cultural Specific Approach within the profession of pharmacy looks at the expansion of pharmacist-led Medication Therapy Management (MTM). Hepler and Strand (1990) emphasize patient-centered outcomes and relationship-building equally as clients, in this case, clearly desire to be informed participants in their healing process.

Literature informs that provider competency is a trait, explicitly linked to data that reflect the social and culture capital of resource-poor communities. The results of the analysis of the Anishinaabe reservation data are significant (Whitbeck, Sittner Hartshorn and Walls, 2014), because of the increasing burden in local health care and the associated

severity of chronic illness, such as diabetes mellitus II and substance use disorder. Diagnoses of diabetes are shifting with more funding required from preventative stages to more patients in chronic stages, with additional increases in young people less than 55 years of age being diagnosed each year according to the report of tribal data (Narayan, 1996). Research is one step in this direction to understand better the factors play into the provision of care for native diabetic patients, explore expectations the patients have for their health care organizations, and the steps needed to improve communication with the patients on terms they best respond.

This study warrants further exploration to engage the potential to the patient in meaningful healthcare dialogue, nurture the relationships by better-informed practitioners, who now are active in the community, and instigate reflexive therapeutic judgment that can bring reciprocal value to changing the course of disparities on rural reservations. Continued research must be done to capture the longitudinal changes using the *a priori* Cultural Specific Approach on the rural reservations.

Provider competencies as outlined in more detail accentuate training needed for the pharmacist (King, 2006). Additionally, knowledge assessment of the typology is prevalent in native communities, customs, traditions, and "calendar" of social, cultural, and ceremonial events that are community-engaged, and values that define the variations within native life. As such, King provides a quick list of practitioner competency skills that reflect skills and attitudes that reflect the capacity and willingness to work with clients as rural reservation residents (p. 8-10).

An important strategy that must follow discussion is moving past the

competencies and making an effort to engage the actions that reflect the learning. Among the initiatives proposed, while transforming the health belief models for American Indians, the partnership with the pharmacist profession is highly significant to health services, researchers and policymakers alike. From adjusted practice and praxis, the trained pharmacist as the provider is well suited to provide the medication management services that communities as rural reservations require to better their position.

Finally, these recommendations address the pharmacy profession as the unique medical profession that can make this change and alter medication experiences for the benefit of the patient. Through community education of medications, education on improved practices of herbal and alternative (chemical) medicines, these actions provide needed changes in the Indian Health Service, Tribal Health Providers (Tribal 638), and Urban Indian Health (I/T/U) formulary. For the time, current obligations include advisement within the tribal health boards, mandated policy revision within the National Tribal policy commissions that are aligned with the IHS, and Indian Health Board, and federal pharmacists' registry.

# CHAPTER 4

# METHODS

## 4.1 Methodological Framework

The objective of this study is to codify the Cultural Specific Approach as *a priori* construct to establish a new framework of healthcare modeling through the relationship of the Anishinaabe peoples' cultural specific construct of Bimaadiziwin. The concept of the Cultural Specific Approach was introduced by the primary investigator in a series of regional community medical facilities and treatment centers in response to a major opioid epidemic on neighboring Ojibwe reservations in 2017. A working Cultural Specific Approach Model approved by the senior leadership of the clinic commenced in response to an emergency action plan (EAP) due to the numbers of fatal overdoses occurring weekly. The Cultural Specific Approach enabled a non-judgmental relationship "meet them where they are" dynamic approach building upon spiritual values unique to Anishinaabeg that ensures a unique trust bond and an increased alliance of medication education from the clinical pharmacist-provider team partnered with community members and together achieved significance to decrease opioid fatalities and overdoses within a brief period.

The fundamental knowledge of the specific approach to health among tribal members disseminated among communities and although readily known as a component of the cultural health belief for Ojibwe nations, the Cultural Specific Approach Model is embraced as a protective measure to change or augment behaviors of residents in treatment or those seeking knowledge of medications for personal edification. This nomothetic study

exemplifies three case study findings that capture progressive dimensions of the Cultural Specific Approach. These ordered case studies 1) thought/theory; 2) application; and 3) policy present as one phenomenon (Bimaadiziwin) that contributes to the understanding of the community-specific aspects and clarify best practices in the optimization of health care among adult Anishinaabe reservation residents with diabetes and substance use disorder.

### 4.1.1 Propositions

Propositions framed within the Cultural Specific Approach are: (1) to what extent do phenological or traditional practices contribute to the Cultural Specific Approach, (2) what is the relationship of spiritual and healing practices contributing to Cultural Specific Approach, (3) what role does happiness discriminate in the psychosocial relationship to Cultural Specific Approach, and lastly, (4) what best defines professional cultural competency for practitioners to enhance patient's perceptions of health and reported outcomes?

### 4.1.2 Study Design

This study utilized a qualitative, embedded single-case study explaining the Cultural Specific Approach (one phenomenon) based on four propositions of the Cultural Specific Approach that seeks to explain presumed causal links in real life interventions of chronic illness and addiction. Three case study units are findings of mixed methods research using categorical aggregation and direct interpretations after analysis. Case Study One is based on provider interactions with the practitioner to adapt to the Cultural Specific Approach as a first response. Case Study Two is based on pharmacist-as-provider

interactions with clients who are adults over 18, Anishinaabe federally enrolled members, having comorbid health conditions, and pursuing treatment for substance use. Case Study Three is based on a clinical policy change that is initiated at the community level and rises to the recognition at the federal level.

### 4.1.3 Setting of the Study

Rural Ojibwe reservations in Minnesota and Wisconsin that operate health clinics and treatment centers and tribal leadership national forum (Figure 7.).

### 4.1.4 Case Study Unit 1. An Informed Method Utilizing the Cultural Specific Approach: Supporting the Clinician Response to Crisis after Overdose.

The first case unit describes a narrative of early response criteria to crisis that was initiated within a short time period. The early response is a theory building case that collects all data together, converging all data points to formulate analysis. Crises support is selected to reveal the efficiency of the Cultural Specific Approach that facilitates emergency decision-making skills and supports clinicians after experiencing social crises, such as an opioid overdose that affects extended family members as well as the community.

Objective: To explain the support processes for providers who encounter opioid overdose in a clinical setting using the Cultural Specific Approach Model.

Setting: Rural clinic hospital.

Analysis Methods: Explanatory, single case study phenomenon of the Cultural Specific Approach with embedded units.

Contribution to Practice: This case study contributes an innovative approach to broadening the pharmacist's role in collaborative team building with the medical provider. This narrative provides the framework for provider status in state description as well as strengthening the Indian Health Service model for pharmacist providers (Duvivier, Gustafson, Greutman, Jangchup, Harden, Reinhard, and Warshany, 2017).

Narrative:

Within a short time while the emergency ambulances sirens' blazed, the medical team was organizing to meet the rush of another opioid crash fatality. This time, the Pharm.D. was on the team, having just a few days of interaction with the medical providers. In addition to the team, the clinic had authorized the inclusion of a clinical psychiatrist, a specialist in telehealth to participate and another pharmacist whose specialty was chronic conditions like diabetes, renal disease and excelled at 'thinking outside the box.' Between the emergency management first responder, pharmacists, ambulance attendants, lawyers, psychiatrist, nurses, behavioral health, and the medical officer, a rescue team had been mobilized. Modern medicine and technology were now blended to form the action phase of a tribal community clinic medical emergency team.

The newly formed team was initiated as a response to an emergency action plan (EAP) to address the opioid overdose fatalities which were overwhelming the small, rural communities near a tribal community. Armed with more than Narcan (naloxone), the rescue team approach was situated to provide emergency and continued holistic care to the

individuals who had succumbed to opioid addiction. The ravages of the opioid crises were at an all-time peak and not another day went by without any county support as all cases were brought to the hospital or the morgue.

The pharmacists were trained in community conversations, having meetings that were held each month and various community participatory events now were on the schedule and part of the duties. Community conversations were a first line approach to visually soften the appearance of seeing a provider in their midst, outside of the clinic environment. These meetings were informative and enjoyable for the various supportive medical staff present and the community members to discuss health issues openly. The pharmacists were part of a demonstration project to integrate into the community to establish a relationship with community members in order to reduce disparities and broaden the cultural specific approach theory in practice. The pharmacists were chosen because of the skill and compassionate care qualities they exhibited upon hire, but there was also room to partner in the hospital and clinic inpatient department as a dispensing pharmacist, if so desired. Many of the pharmacists were more than encouraged to step out from behind the pharmacy pick-up window to travel around and present education demonstrations, meet with students, and with elderly residents in the nursing homes.

The administration was advancing the theory of a Cultural Specific Approach that could bring relief to understanding the community norms and stem the adverse drug events that were rapidly taking lives each month. Nothing else had worked in the past and now was the time to use the essence of a robust ethnic stake in promoting the tenets of health belief theoretical constructs. This step was the beginning of a radical new approach to

healing—no judging, no police calls, and nothing but compassion and direct medication education dialogue through individualized participation within the inner circles of the community people. The resources needed for the pharmacist-led approach were few because the clinic administration was utilizing grant funding and services were billed through appropriate provision.

There were more participants in the community who had first-hand collaboration with the administration to make this plan work. The grassroots organization was supported and built over time from a few members to a core of dedicated members, some addicts themselves in recovery and some who had lost family members to a drug overdose. Day and night the groups would contact the pharmacist and administration to gain insights into ways to address the many calls for help from community members. This factor was another step to developing the Cultural Specific Approach Model because the grassroots organizations, whether in the city or rural areas, could mobilize and find the individuals who were needing help. This help could be anything from a phone call, sitting with them as they detoxed, picking them up at the jail, hospital, or treatment center, or finding treatment centers to take them at the first opportunity. This plan to saturate the community with resources seemed the most likely plan to work.

Within days and weeks, the treatment center was filled with clients who wanted to rid their bodies of the drug dependence and enjoy life as a member of the community. The police were also in the plan to surrender drug addicts to treatment instead of jail, utilizing a peer-drug platform, as the effects of heroin and methamphetamines were treated as a medical situation, not a criminal event. In case, additional support therapies were needed,

the psychiatrist for telehealth (telehealth is the first triage service unless further clinical services are recommended, then it is referred to a telemedicine) was on call to assist. The pharmacists delivered hundreds of community materials to educate all ages on Narcan (naloxone) administration and CPR, including AED training. The outreach specialists were continually busy in all areas of the state presenting educational information sessions and clearing up any misconceptions about drug overdose. The idea was to present the physician and pharmacists as a 'trusted entity' and making the most of their presence, to engage regular dialogue with all members of the community. Blending these actions with the Cultural Health Belief model of Bimaadiziwin, was contiguous with native beliefs in healing and positivity.

All these actions helped the community begin to recover from the opioid crises and also laid the foundation for the promotion of the Cultural Specific Approach for this community. It was known as Bimaadiziwin and was the basis for love and compassionate care (Benton-Benai, 1979). Not only did the Cultural Specific Approach bring in clients to the hospital and clinics, but the cultural specificity of Bimaadiziwin emphasis also reunited all people who were eager to accept one another, no matter the circumstances. The Cultural Specific Approach Model exercised the philosophical tenets that were unlike any medical intervention. Even as the city physicians came to visit and observe, the Cultural Specific Approach was unwavering in its mission with the community members. The Cultural Specific Approach Model was a modification that garnered a better plan for recovery and sustainable value for life.

The treatment center was facilitated to treat as an abstinence facility as well as

medication-assisted treatment (MAT) program with Suboxone (buprenorphrine/naloxone). Vivitrol (naltrexone) was also offered because of the positive reviews evidenced by other native treatment centers. However, the best practice for the hospital and clinics was the integrative, holistic approach of Bimaadiziwin and the encouragement from the community.

Even though the community members were taken care of through treatment, the providers were caught in an unusual situation. Within the Indian Health Service, there are special provisions that mandate that the prescribers complete the additional training required to receive the Drug Enforcement Agency waiver that is needed to prescribe buprenorphine/naloxone (Toedt, 2018). In addition to the waiver, the Internet Eligible Controlled Substance Provider exception to the Ryan Haight Act allows IHS-designated providers to prescribe Medication Assisted Treatment over telemedicine when the patient is not in the presence of a DEA-registered practitioner and regardless of DEA facility registration status ("Improving Access to Remote Behavioral Health Treatment Act 2018," 2018). This exception expands access to the full spectrum of treatment options for opioid use disorder (OUD) to individuals in rural and remote areas. An example where this policy exception could be used is in a remote Alaska village clinic that is staffed only by a community health worker or in any state where provider shortages are the case.

The case study approach to analyze the team approach was selected to provide the best support for the medical team members who were actively meeting with those who had overdosed, were in treatment, and for those family members who had experienced a fatal overdose. It was assumed that the administration was aware of the burden of working with

opioid use disorder and believed that a collaborative approach was best handled by many professionals and lay people who were familiar with treatment courses.

The experiences of overdose, primarily when its due to suicide tendencies alone, can manifest in symptoms of avoidance, shock, guilt, shame, fear of blame and self-doubt (Wurst et al., 2013; Tillman, 2006). The hospital and clinics were rallied to provide support for clinicians with collaborative meetings, dinners, quality improvements in practice delivery, consultations with local primary care physicians, and with specialists who came to the area for their insights. At first, many record-keeping items had to be collected, but after a short while, the parts fell into place. For instance, after each case, the record log was updated, and appropriate indicators were aggregated for data purposes. This system did not leave much time for the providers to decompress or develop needed time for themselves. The area of study in this case research could use more insight from other physicians who work primarily in this field. Drug overdose is complicated and requires behavioral health to align with the medical health forum. It is the belief that medicine, and pharmacy must undertake the psychosocial pharmacologic treatments until the opioid crises cease. Another area of concern is the vast area of medical waivers that have to be undertaken when dealing with substance abuse. Providers are not given adequate time to settle documents with their patients and proportionally leaves less time to take care of the electronic health records adequately unless they have been trained.

Results: There were daily opportunities for the patient to engage with their provider pharmacist and had successful treatments with more providers involved in their care.

Conclusion: Pharmacists should be given the option to treat under the supervision of the

physician as a team. Providers and pharmacists are compatible to work collaboratively for medication-assisted recovery efforts and present a unified team approach that is successful. Providers who are pharmacists are well-poised to bridge therapeutic interventions in the field of opioid use disorders. This study helps build theory and supports the premise for a cultural specific approach method to health.

### 4.1.5 Case Study Unit 2. Pharmacist-led Community Engagement and the Role of the Pharmacist to Understand Medication Assisted Recovery with the Cultural Specific Approach.

The second case unit describes the outreach utilized within a community to understand how the role of the pharmacist emerged to qualitatively enhance and support efforts in dealing with substance use disorder.

Objective: To describe the outreach strategies implemented in a community to improve opioid safety and to discuss why the pharmacist role in medication-assisted recovery was successful.

Setting: Rural health centers including tribal federally qualified health centers (FQHCs) and resident community areas, that may include underserved medical areas.

Analysis Methods: Explanatory, single case study phenomenon of the Cultural Specific Approach with embedded units.

Contribution to Pharmacy Practice: Innovation to theory building using the Cultural Specific Approach to better understand the effectiveness of the provider relationship construct.

## Narrative

In 2017, more than 70,000 people died from drug overdoses, making it a leading cause of injury-related death in the United States. Of those deaths, about 68 percent involved a prescription or illicit opioid (Centers for Disease Control, 2019). The recent opioid epidemic reached widespread proportions among all ages among tribal and rural area communities (Duvivier et al., 2017; Department of Health and Human Services, 2016). On federal reservations, the cost of death from overdose is far from just the individual but considers the community role in weighing factors of economics and social impact. Often the cultural norm includes the whole community coming to the wake, feasting for four days, and funeral preparations expressed in distinctive tribal representation.

## The Role of the Pharm. D. in FQHC clinics

Pharmacists as Doctor of Pharmacy are recognized as trained providers within tribal clinics, IHS clinics, and federally qualified health centers (Part D Medicare), and within that provider role, they are better prepared for recognizing the magnitude of the unintentional drug overdose experienced as community-wide substance abuse. Federally Qualified Health Centers (FQHC) are health facilities that serve the underserved area, qualify for funding under Section 330 of the Public Health Service Act (PHS), offer a sliding fee service to clients below 200 percent of the federal poverty level (FPL); and qualify for enhanced reimbursement from Medicare and Medicaid. FQHCs also provide comprehensive services for preventative health services, dental services, and mental and substance use services (Health Resources & Services Administration, 2018). FQHCs are not concurrently approved as a rural in-patient health clinic, and this point clearly explains

the purpose of utilizing pharmacist-as-provider with a physician collaborative workforce (Guglielmo & Sullivan, 2018) through the grandfathered tribal FQHC health facilities for pharmacists (Jones, 2018; Indian Health Service, 2016b).

Within the administration of a tribal clinic in rural areas, often located in medically underserved areas (Indian Health Service, n.d.), there are everyday experiences that challenge available resources to serve clients, such as inadequate facilities to treat addiction and the post-treatment transitional programs necessary for those clients graduating from a long-term substance treatment center. One of the most substantial gaps is the availability of enough clinicians to assess incoming clients through the treatment center (Tupper, 2016; Stanley, Harness, Swaim and Beavais, 2014) and the decision to utilize Pharm. Ds. on the clinical team was deemed appropriate. The pharmacists collaborated as a member of a provider association team and gave the physician ample evidence for necessary recommendations that pain, or chronic conditions required (Tipps, Buzzaard, and McDougall, 2018). Prescription Drug Monitoring Program (PDMP) reporting was a necessary measure that encompassed local networking and cut down on the prescribing for non-pain treatment. Also, the clinics reported on the morphine equivalency dosing(MED) as a threshold.

Treatment facility and cultural approach integration

The treatment facility was at capacity almost at once when the treatment center commenced. This particular treatment facility was culturally centered, meaning only the Culturally Specific Approach for Anishinaabeg was the core of the programmatic-centered practice. As clients progress through the program in-house, their progress was evaluated

for other underlying behavioral and psychosocial conditions; but primarily, the attention to medical needs was the priority considering the chronic use of substances and the rate of addiction characteristic of unintentional opioid use disorder.

## Forward Challenges for the Pharmacist Profession

While discussions on opioids and overdoses are prominent, there are still vast opportunities for pharmacists to get involved beyond the dispensing role. Pharmacists can and should be recognized who are on the front lines of the opioid drug epidemic initiatives (Morton et al., 2016) such as those who improve and promote the life-saving naloxone opioid overdose reversal drug (Jones, 2018; Duvivier et al., 2017; Indian Health Service, 2016b; Chambliss et al., 2012). But, pharmacists in an integrated role within the community are often aware of patients who are receiving a high dose or recognize clients who potentially may abuse prescription opioids or are likely doctor shopping. Given an opportunity, pharmacists can open meaningful dialogue with clients to better educate them about their therapies, preventing adverse effects, such as overdose. Pharmacists recognize that the typical pharmacokinetic properties of several opioid formulations are inapplicable during opioid overdose because of the changes in patient-specific factors affecting absorption, distribution, metabolism (weight), and elimination. Research initiatives such as the Precision Medicine Initiative (Precision Medicine, 2016) have entered the research roundtable in discussions about factors that describe Native American metabolism (Henderson et al., 2018). Pharmacists employ their understanding of opioids and other potential mechanisms of action to help determine appropriate diagnostic tests and reversal methods.

The American Pharmacists Association has previously identified pharmacists' role in addressing nonmedical opioid use, opioid use disorder, and diversion, which include: (1) identifying potential opioid use disorder by evaluating patients and prescriptions (Chambliss et al., 2012); (2) managing the risk of opioid misuse by establishing policies and guidelines related to opioids that address a variety of situations (Kolodny and Frieden, 2017), assessing patient risk for opioid misuse (Chambliss et al., 2012; Indian Health Service, 2016b) and discussing issues through community-based participatory research, relating to a patient's pain management in the context of a tribally- based medication therapy management visit (Indian Health Service, 2018); and (3) addressing confirmed opioid use disorder and diversion by contacting relevant parties or referring the patient to a team- based provider (Indian Health Service, 2016a; Morton et al., 2016).

Several strategies are listed (see Table 1.) to strengthen the pharmacists' role in building a treatment program for opioid use disorder that involve their recommendations aligned with the specific cultural health initiatives. Additional variables may add to these strategies as deemed fit, but the main reason for constructing this table was to illustrate the more prominent community responsiveness and intervention outreach possibilities that a revised job description for a Pharm. D. trained pharmacist can offer based on meaningful collaborations. These strategies were pharmacist-led and very productive. Efficient use of time for management was successful because the pharmacist. already possessed the medication knowledge, expertise, and knew the community specifics. The research studies emerging from initiatives like this are productive and engaging. Based on the literature in

current news, more opportunities continue for pharmacist-medical provider teamwork that captures best practices for continued care therapies.

**Table 1.**
Strategies for the Clinical Pharmacist and Provider Team Collaboration in Building an Opioid Treatment Managed Plan

| *Strategy* | *Goals of care* |
|---|---|
| *Prevention* | Responsible prescribing and reporting |
| | Adherence to guidelines on safe medication prescribing |
| | Knowledge of community values – 'hugs, not drugs" |
| | Prevent opioid deaths by ready access to naloxone, CPR |
| | Harm Reduction: Clean needle exchange |
| | Standing orders for opioid reversal |
| *Negotiation* | Develop community relationships outside of work hours |
| | Attend drug forums to stay relevant |
| | Share resources to others to teach about medication education and safety regularly |
| | Share professional research to colleagues |
| | Share professional opinions to stakeholder partners |
| | Design policy and guidelines based on stakeholder input |
| *Research* | Attend more federal and national meetings to network |
| | Do research projects in the community |
| | Read to know, laws and policies revising |
| | Develop community leadership to support pharmacy policy |
| | Develop cultural communications (brochures) to broaden |
| | Expand competency to other areas: ED, Toxicology, CHAs |
| | Disseminate relevant material to federal partners |

*Note.* Abbreviations: CPR: cardiopulmonary resuscitation; ED: emergency department; CHAs: complementary health approaches.
Provider roles conducted and associated in a substance use disorder management plan. Prevention, negotiation, and research were three areas that contributed to a comprehensive approach in opioid use disorder treatment therapy.

## Results

### Initial observations:

There were challenges at first with the current state policies until the unique Anishinaabe treatment center policies were initiated. The facility was native owned and administered by a native holistic approach to health, life, and spirit – Bimaadiziwin (McIntosh, 1843). The approach to saving lives through the native belief system was successful as clients were integrated into a healing system they recognized as their own culture.

The most significant accomplishment was the idea that health and wellbeing were centered on the construct relationship of Ojibwe zhawenimaa, "family, relationship," healing the whole person, mind, and spirit with concordant behavioral activities and teachings. The clients were given a native approach to healing with sweat lodge teachings, traditional practices and activities that further developed the sense of healthy living, gender roles, acceptance of self with dignity, and abstinence from the 'black spirit.'

Pharmacists were sought out immediately as each client presented before treatment and during treatment. The expertise to understand drug interactions in drug addiction was paramount, although the guideline to address pain management for chronic illness was also a primary topic with the physician and behavioral health team.

The treatment center had a multifaceted strategy to address pain: (1) plan a responsible use of opioid contract, (2) promote integrative health belief practices with the cultural approach with other mindful activities, (3) reduce the dependence on opioids through taper avoiding ill-advised condition of 'cold turkey,' (4) create a continuum of best

practices to educate, and, (5) utilize peer and family support through norming a spiritual, cultural lens.

The case study results are organized in the following sections: (1) pharmacists respond to the needs of a community; (2) pharmacists as medication experts; and, (3) pharmacists in the community.

1) Pharmacists respond to the needs of the community

The pharmacist-led community dialogue sessions were highly effective and were the first-ever experiences for many individuals to interact with a Pharm. D. outside the work environment of the clinics. Meaningful communication between client and medical team increased significantly and contributed to ongoing useful insights that broadened the opportunities for substance use treatment 24/7. For the first time, pharmacists created liaisons within the community members that opened the dialogue with networking opportunities to extend outreach to treat. News spread quickly of available treatment and induction through word-of-mouth and social media; trust was positively developed, and word of this spread quickly among the communities.

2) Pharmacists as medication experts

Pharmacists were first to provide naloxone education and safe disposal of medications to the community residents. Pharmacists worked more hours, and many felt highly self-motivated due to the positive response from the community residents. Pharmacists with their strong pharmacotherapy knowledge desired to engage in more in-depth and more extended consultation with residents as the trust issues were brought into the open. Pharmacists were able to utilize more of the research presented in national

conferences, state-wide and tribal negotiations, and participate through research on the internet beyond the curriculum to assist in other collaborative medication-assisted therapies.

3) Pharmacists in the community

Pharmacists developed an innovative routine to address community trends in spans of higher-than-usual drug activity; pharmacists skillfully administered all the medication training of naloxone and CPR to employees in the communities (Morton et al., 2016); pharmacists were on the front lines in medical emergency calls as best could be informed; pharmacists were able to collaborate with medical examiner's office and police efforts to track opioid overdose numbers; pharmacists-led policy changes in tribal, regional, and national conferences to build the theory of cultural specific approach as a model; pharmacists conducted medication reconciliation for elders who represented a neglected area of healthcare and geriatric interventions; school-age children were included in early interventions to "speak and say" something if drug behaviors were evinced in the household (Parker, Lopez-Quintero, and Anthony, 2018); and, pharmacists were present in negotiations with policy and procedures in clinical health care administration initiatives. When adhering to IHS protocols, the PDMP and MED thresholds, the clinics met the Chapter 32 PDMP state requirements (Indian Health Service, 2016a) as well as purposes and goals of the Chapter 30, Chronic Non-Cancer Pain Management (Indian Health Service, 2018) and were well under the MED threshold.

Discussion:

There were significant changes that occurred with healthcare and treatment policies in healthcare facilities because of the initiation of the pharmacist-led approach to opioid and substance use disorder. Three domains stood out as the program planning commenced: prevention, negotiation, and research. These areas were contributing factors in the successful transition to healthy living for the patients upon completion of the treatment program.

The domain of prevention was pharmacist-led and developed further substantial collaborative meetings with the physician provider as the ideas developed that had an impact on the drug safety concern. The Pharm. D. had considerable time in the community each week, and this interaction challenged the usual role for pharmacists who desired to participate in community education. Following the implementation of the Cultural Specific Approach model in this study, patients express greater satisfaction with their provider, and were more likely to engage and adhere to prescribed recommendations and reported behavioral outcomes in and after substance treatment as extraordinarily successful. Engaging the integrative strategies where the patient remains the focus is an area where the practice and policy need revision within the Indian Health Service. More clinic-based pharmacists expressed greater interest in participating in the ongoing community forums and supervised home visits as the programs progressed.

The domain of negotiation was pharmacist-led and was developed with the intent of disseminating current practices in harm reduction, medication safety, and medication education to professional colleagues and clinic administrators when the regional opioid

response action plans were requested. These action plans were a step to address the rise of opioid overdose fatalities (Scholl, Seth, Kariisa, Wilson, and Baldwin, 2019), traumatic brain injury, and long-term care needs after unintended drug adverse events. It was evident during these discussions that the pharmacist was a vital resource in delivering appropriate and timely information for the clinic administrators. Many informative drug topics were addressed for patients' care plans and long term care, including fee schedules, long term waivers, and insurance coverages after an overdose. It was discovered there were topics about which the pharmacist was keenly aware and contributed to sharing their experiences with other professional members in the audience.

The domain of research for the pharmacist was focused on understanding the laws, or lack of laws and policies that govern adverse drug events, suicide, injury after an overdose, and waivers for long term care and living wills that require a regimen of medications after an overdose. The pharmacists' input to clinic administration and other health administrators at regional and national consultations achieved support from the federal partners as members recognized the value of Pharm. D's as providers in reservation clinics. Current progress encourages revised pharmacist roles in research initiatives and implements care plans for rural capacity building to improve the goals of care. Significant policy changes are on the horizon as evidence emerges that focus on strategies covered through the pharmacist-led initiatives in harm reduction, drug therapies investigations, community responses, and research-mediated publications. Throughout the opioid strategic care plan, the integration of the pharmacists that provided support to community needs, extending their medication expertise, and promoting the pharmacy profession as mediators

for policy changes achieved meaningful program harmonization and saved lives within communities. These fundamental changes will ultimately affect national and federal policyholders who are accountable to report on the state of the opioid epidemic within tribal and rural health centers across the US.

Conclusion

While policy and procedural changes follow federal mandates to combat the opioid crises (Kolodny and Frieden, 2017), laws are insufficient to address the opioid overdose deaths and mismanagement of drugs without the pharmacist at the executive level. Within the clinic administration, it was revealed that the burden of addressing death after overdose had to be exchanged with the pharmacist and medical team because the concerns were always tied back to medication education and what could have been addressed through consistent and persistent education about drug therapy. After tribal consultation meetings at the federal and national administrative level, the main message was still clear, the pharmacists' robust pharmacotherapy knowledge and commitment to relationship-building in clients created the paradigm shift in a successful treatment center program. These examples of daily innovation to decrease opioid use disorder are recommended for national tribal dissemination upon further review.

### 4.1.6 Case Study Unit 3. Effectiveness of the Cultural Specific Approach to Initiate Policy Changes within Community Clinics.

Objective: To explain how principal cultural specific approach engagement guides policy-making within community-based health administration and impacts state and federal

healthcare policy and legislative processes.

Setting: Current federal negotiations with tribal health leadership.

Analysis Method: Explanatory, a qualitative single case study with embedded units.

Contribution to Pharmacy Practice: Policy change

Narrative:

Centers for Disease Control and Prevention (2019) reports death rates from opioid overdoses in a rural area (63%) now exceed urban areas (37%). In 2017, 11.1 million Americans 12 years or older reported misuse of prescription opioids, 2.1 million had an opioid use disorder in the past year; and, more than 42,000 Americans died from an opioid overdose in 2016 (Substance Abuse and Mental Health Services Administration, 2018) .

Results from the 2017 National Survey on Drug Use and Health  Engagement (2018) in healthcare encompasses processes relevant to the patients, clinicians, and stakeholders through strategic goals. Engagement processes contribute to improved health outcomes for the patient, making critical research more patient-centric and relationship-based, increasing the body of useful information to guide policy-making in health care, and motivating the use of relevant research findings (Consuelo et al., 2019). Focusing on the engagement of the pharmacist-led initiatives, our objective is to engage and align research efforts with real-world needs, concerns and questions of patients, caregivers, clinicians and pharmacists, payers, and policymakers.

Accomplishing these objectives are five aims that address important priorities most

notably at the forefront of the healthcare care industry because of the catastrophic events with the opioid crises (Kolodny and Frieden, 2017). These five aims are: 1) define the Cultural Specific Approach framework; 2) strengthen the clinician-pharmacist team; 3) Improve the Health Information Technology-Management (HIT-M) data acquisition, statistical analyses, program evaluation, and dissemination; 4) expand and develop opioid transition programs and recovery treatment options; and, 5) expand and develop social and educational services, pharmacy practice management, and dissemination. This study is unique in its efforts to support recovery services that have proven successful based on the recognition and adaption of the Cultural Specific Approach. The following initiatives are qualitative method snapshots of the enhanced opioid overdose surveillance programs.

The first aim accomplishes the objective by defining the Cultural Specific Approach framework. The Cultural Specific Approach espoused here is a theory modification utilizing internal values and core beliefs central to the relationship of the patients' perception of health to effectively improve and manage health outcomes. Defining the cultural specific approach to healthcare modeling is the first step in progressing through a successful program of quality measures for a community. The success of a highly engaged program is theoretically driven by the responses by the people, so it is logical to start with the conceptual model to guide the next steps of research.

The second aim accomplishes the objective by creating a medical partnership team for opioid consultation between the physician and pharmacist. Direct inclusion of the Cultural Specific Approach as a pivotal, first-line approach offers health practitioners who serve American Indian patients a better understanding of how best to communicate with

tribal or indigenous community partners. The first line of communication involves the set of questions to frame how the clinicians and pharmacist can manage drug therapies, medication response, whether in treatment or prevention. Questioning is part of the relationship building component between the pharmacist and clinician and the community members. For example, when the pharmacist and medical doctor met with community members, the people had many questions to ask about opioids and expectations and the responses were always factual and genuine. The relationship between the doctor and pharmacist was portrayed as a partnership and the people came to trust the alliance, and all ages of residents came to see and hear the presentations. Within the results of survey questions, the preliminary data also supported this proposition. There were many opportunities to expand upon question and answers regarding the opioid trainingmeetings significantly beyond the clinic over-the-counter dialogue.

This is another valuable area where the newly adapted pain care brochure on tribal Medication Therapy Management (T-MTM) was beneficial and the pharmacists were able to disseminate valuable medication information as well as Narcan (naloxone) training (Morton et al, 2016; Offices of Rural Health, 2017). Tribal Medication Therapy Management (T-MTM) is an original term that broadly defines two aspects: (1) drug-drug specificity for indigenous populations; and, (2) medication management and drug therapy plans. This terminology opens the possibility in drug research that certain drugs respond indiscriminately in native and indigenous people. And, while the research in tailored drugs for an individual commence with indigenous populations (Feero, Wicklund, Veentra, 2018), there are possible changes that affect how drug therapies are managed in an MTM

plan (Centers for Disease Control, 2018a).

The third aim accomplishing the objective was to expand the health information technology and management team. This expansion was necessary due to the changes in data questions that generated different forms of data that were unmanageable and affected different billing operations. The change also coincided with the emergence of the new technology of the electronic health record (EHR) and changes with the Current Procedural Terminology (CPT) coding for rural areas. In previous years, there was not a need to look this closely at the medical records with the older system but with the basic foundation changing, the EHR had to advance to support data health interoperability.

On rural reservations and in rural communities, the federal government has a trust responsibility referring to updating and modernizing the physical and technological infrastructure within the Indian Health Service (IHS) and tribal health facilities. The federal government has not met its obligation to updating the Resource and Patient Management System (RPMS) and most tribes have had to pay for a number of systems to utilize clinical and practice management applications (National Indian Health Board, 2018). Another factor in understanding the need for adequate services in EHR medical documentation was the added functions of all service areas to address the integration of the opioid recovery initiatives, including a number of supportive behavior and social services now being part of contract billing and reimbursement.

The fourth aim to accomplish the objective was to expand opioid transition plans and programs that support recovery options for community members. The medical-pharmacist transition team was the first call-to-action to address ill health of a recovering

addict or the sudden impact of an overdose suicide (Stringer, 2018). Since 2017, the proliferation of extremely potent synthetic opioids such as fentanyl and carfentanil has further caused an exponential increase in overdose deaths and underscores the urgent call for action from the medical-pharmacist team (O'Donnell, Gladden, Mattson, and Kariisa, 2018; Centers for Disease Control, 2018b). Rapid response from the medical-pharmacist team was crucial to creating an emergency action plan (EAP) to support clinical life-saving measures. Utilization of the Cultural Specific Approach as a guide to gauge the span of mental health support services found that there were additional services (food, childcare, medical, nursing, social services, telehealth, kinship care, protective care from legal and law services and spiritual) necessary to provide for patients and clients themselves and their families in response to evolving outcomes of drug overdose conditions (Radel, Baldwin, Crouse, Ghertner and Waters, 2018). Often, the pharmacists as providers were the first line of communication who could communicate the drug precautions for the patient upon entering detoxification centers or hospital environments before treatment.

The fifth aim to accomplish the objective expands and develops social and educational services, pharmacy practice management, and dissemination. Social services and transitional services had the most challenges with the policies that must be changed. DHHS reports 50% of overdose deaths and drug hospitalizations to correspond with higher child welfare caseload rates (Radel et al., 2018). Policies to address the opioid crisis include Behavioral Health and Social Work professions as a vital part of the support services team, to ensure that individuals, families, and communities addressing addiction are fully supported. Comprehensive policies reflect the vital role of social services, such

as transitional services and community support services, in helping bridge gaps in care that individuals and families fighting substance use disorders often encounter. More often, community support workers (CSS), such as community health workers (CHWs), community health aides (CHAs) and social workers are key to ensuring individuals transitioning from treatment to recovery have their needs met for as long as two years after treatment ends. This is especially true when these individuals are in their most vulnerable state.

Results:

The physicians were able to spend more time with clients as well as listen to the pharmacists engaged in community dialogue. Creative planning was initiated from all areas of the healthcare team to prevent further opioid adverse events. Whole healthcare initiatives were pharmacist-driven and partnered daily with the medical team. The pharmacist teams went on rounds to the treatment center and engaged with the medical team on the opioid discussions. In all cases, dissemination and public give-back to the community provided the responsibility and opportunity to review and expand upon the next steps.

Discussion:

The principal feature of the *a priori* Cultural Specific Approach Model applies its precepts in a participatory manner to guide professionals to make informed decisions for treatment, based upon expert cultural collaboration and cultural competency. The results of the opioid initiative were significant and will provide the basis for further replicability and dissemination of findings for other drugs that are abused like

benzodiazepines.

The first aim to define the Cultural Specific Approach framework was a meaningful experience for the clients and administration of the health facility. The cultural approach opened communication and responsive dialogue between patients and clients with the provider team. The relationship of trust building and reliance between the providers and healthcare team improved as well as the patients they served.

The second aim to expand the clinician and pharmacist team was a relationship that should be recognized in other studies because it was successful in the opioid crisis. Success for this initiative was measured by the numbers of new clients, lowered prescriptions, increased revenue, improved health status, and continued care behavioral change. The clinician-pharmacist team greatly utilized information they gathered each time they met with the community members in meetings. Ultimately, there were more prescriptive therapies developed in response to the community problems each time as numbers of clients grew.

The third aim to expand the health information technology and management team was pivotal in preparation for the rural health centers administration to transform the electronic health record (EHR) system. The EHR transformation was necessary in order to collect data from within the clinic and outside health facilities. Identifying best practices in IT is a current challenge that affects all health facilities.

The fourth aim expands opioid transition plans and programs that support recovery options for community members and contributes significantly to improved health promotion among community participants, ensuring trust relationships and

improving health inequities.

These significant results are foundational to initiate policy changes, revise and dismiss old policy, and use the reformed systems to improve healthcare. The main improvement focused on pharmacist-led healthcare initiatives using the cultural specificity of the Anishinaabe nation. This improvement began with a significant number of policy revisions before actions were enabled. After several meetings at national conferences with federal officers and nationally-recognized opioid specialists, the significance of policy change based on the pharmacist-medical team corroboration was the most meaningful change.

The fifth aim to expand and develop social and educational services, pharmacy practice management, and dissemination of findings. Social services and practice management policies were updated, and additional activities were enacted as a result of the opioid prevention services to families. There were a number of changes that had to be addressed with the state department and federal agencies that oversee funding and other research grants for various stages of opioid recovery.

As a result of this last aim, the dissemination of the complete response to opioid care is provided upon review with the community hospitals and community. Further, the enactment of the policies helped to provide an expanded framework of practice management and accountability with increased integration of pharmacy education, medication management, and evaluation. These policies help drive a new approach to medication management and opioid prevention studies research.

Conclusion:

Investments should be made to improve the healthcare initiatives listed here to support rural communities. Local community hospitals and clinics are poised to create new policies in regard to action plans for drug abuse prevention and opioid use disorder. Transitional houses and sober villages are two policy-driven initiatives that must be addressed by the Congress and the relevant supporting documents can be collected through the data. The significance of data-driven healthcare initiatives is recognized by tribal leadership and state commissions and finally, with additional political support, the initiatives make their way to the Administration and Members of the Congress.

According to the federal trust responsibility, in the case of IT support, Appropriations Committees should provide a separate, dedicated funding stream to improve Health IT at IHS facilities. Authorizing Committees (House Natural Resources Committee/Senate Committee on Indian Affairs) should provide authorized funding for major Health IT and Telehealth upgrades at the IHS (NIHB, 2017).

As practice care management assessments were developed, the core decisions to engage with the community and pharmacist-physician teams completely changed the direction of clinical administration when it addressed the various phases of the opioid challenge.

### 4.1.7 Evaluation of Research Outcomes and the Cultural Specific Approach Model

Qualitative evaluation of the Cultural Specific Approach model was achieved

through many reviewers of the healthcare team and expert outside reviewers at different levels of tribal and national health administrations. The expansion of the role of the pharmacist was effective to address the efficacy of patient care and promoting collegial communication with the medical provider. This cultural specific approach study is replicable to other agencies. Future study will enable quantitative methods to evaluate the validity and expand the inclusion of additional variables that best fit the model.

### 4.1.8 Reliability

Reliability is the degree to which the assessment tool produces consistent, repeatable results. In other cases, reliability can be tested through a chain of evidence, descriptive measures of five tribal communities from Minnesota and Wisconsin, identifying similar or same content, construct or item wording in survey questionnaires and patient dialogue with content experts. In this study, reliability was achieved through the results of the patients' successful transition in treatment and 'buy-in' from federal partners who are considered content experts.

There is only one linear version of Bimaadiziwin however expressed in many forms, and it relies on the presence of cultural and historic iterative tradition. Those are the main assumptions to expect a higher true score underlying the continuous facets of' Bimaadiziwin-thinking' expressed among elder Anishinaabe respondents and those respondents of a certain age category (Figure 8).

### 4.1.9 Validity

Validity is the degree to which a variable represents what it is intended to access.

There are three ways to establish validity in qualitative case study technique as Construct validity, Internal validity, and External validity (DeVellis, 2012). Construct validity is examined by focusing on data triangulation (Yin, 2014) with the analyses of many sources of provider interactions but aimed at corroborating the same finding of Cultural Specific Approach. Internal validity is examined in this explanatory study by using logic models addressing alternative explanations. External validity is examined by how well the bounded questions represent all aspects of the phenomenon under study.

**4. 2 Models and Assumptions**

In this analysis, the literature review informs that research studies exist that define cultural practices because of their contemporary use in explaining native health competency theory but still omit the construct of the health belief of the Anishinaabe, Bimaadiziwin, in their design.

Four assumptions guided the development of this study:

1) Understanding and incorporating Bimaadiziwin Cultural Specific Approach constructs will improve overall practitioner-patient interactions.

2) Bimaadiziwin Health Belief constructs improve patients' trust in practitioner prescribed medication therapy and can promote the groundwork for changing health behaviors.

3) Knowledge about cultural roles and expectations should be useful in the strategic planning of health practices, especially on rural reservations

4) By knowing about the complementary approaches to plant and spiritual healing

practices, pharmacy and tribal leaders in the health field can effectively assess and influence medication practices among its residents.

# CHAPTER 5

# RESULTS

## 5.1 Overview of Results

The study results are organized with the following sections as follows: (1) the methods approach; and, (2) the care approach highlighting the cultural specificity of a community complementary to the Cultural Specific Approach Model. Case studies serve as examples of the progression of the cultural specific model in theory and application. Both the method and care approach converge in forming the theoretical construct of the codified Cultural Specific Approach. The study was experience based on three Anishinaabe reservations that qualified as Health Professional Shortage Areas (HPSA) and served 455 patients in long-term care for diabetes and substance use disorder. Eight IHS providers and twenty-six health care administrators were integral to achieve the objective of this study and disseminating the thought and theory of the cultural specific approach to their own tribes.

## 5.2 The Methods Approach with the Conceptual Framework

The objective of the study was to codify the Cultural Specific Approach Model as an *a priori* construct before all other variations of health belief theory. This new model establishes a responsive framework of healthcare modeling through the relationship of the Anishinaabe peoples' culturally specific approach construct of Bimaadiziwin (Benton-Benai, 1979). Bimaadiziwin is formally understood as a 'good life' and encompasses seven

teachings: Nibwaakaawin (wisdom), Zaagi'idiwin (mutual love), Minaadendamowin (respect), Aakode'ewin (bravery), Gwayakwaadiziwin (honesty), Dabaadendiziwin (humility), and Debwewin (truth). Understanding the relationship of the variables (Figure 9) that constitute a basic foundation of the native Anishinaabe seasonal practices, spiritual and healing relationships, and cultural expressions explain philosophical happiness.

Propositions framed within the Cultural Specific Approach are: (1) to what extent do phenological or traditional practices contribute to explaining a cultural approach, (2) what is the relationship of spiritual and healing practices contributing to Cultural Specific Approach, (3) what role does happiness discriminate in the psychosocial relationship to Cultural Specific Approach, and lastly, (4) what best defines professional cultural competency for practitioners to enhance patient's perceptions of health and reported outcomes? These propositions are answered in a nomothetic theory building approach such that all data are relevant to a populations' descriptive emic and etic culture. There are continuous scales that can enumerate the individual presence of each variable, embedded units that may be overarching or latent, but the main assumption is that the variables exist and cannot be fully measured except for a nominal scale of measurement of a 'yes or no.' If studies dichotomize a continuous variable, it stands to lose efficiency of the instrument of measurement and results in loss in correlation of other measures.

This clarification is meaningful in many studies with native communities when researchers attempt to categorically measure the value of traditional activities and spiritual healing practices and lose out at the conclusions because there are no explanations that make sense unless they understand what it really means to be a member of that community

of people, in this case, a tribe. Rather, the most appropriate manner of research is to initially observe that the tribal designations already predict the defined culture and natural processes of health and wellness (Figure 1). Then, build the program from that point forward (Figure 4). For example, the Cultural Specific Approach model was used to guide the community-based participatory research initiative, Precision Medicine case study, for nicotine addiction because it held pharmacogenomic potential for understanding the addiction process and why it occurs more frequently in populations such as Native Americans. Depression-Alzheimer's research and lung cancer surveillance studies are two additional studies within Precision Medicine that for the first time are governed throughout the length of the study by principles of Anishinaabe cultural health belief (St. Germaine, personal communication, July 13, 2017). This concept was important to point out as the results of this study are indeed comprehensive but yet, simple in two aspects, pharmacist-led initiatives excelled by developing the cultural specifics of a community-enhanced relationship into practice that built trust; and, pharmacological knowledge expedited recovery through demonstration of a value-based concept of cultural specific approach (Wesson and Kitzman, 2018).

The methodology of the explanatory theory was based on actualizing the Cultural Specific Approach model (case study units 1-3) on the first day of the highest overdose cases encountered. Upon three-month's time, there was a significant and rapid turnaround of the surveillance of overdoses and reduction in the numbers of overdoses. Clients entered treatment and community participants clamored for assistance to better understand the opioids that had entered their rural communities. During the highest rate of overdoses, the

approach to understanding the cultural aspects that defined a community and endeavors of the pharmacist-led medical team was apparent. The Cultural Specific Approach Model had attributed to reversing numerous fatalities and invoked a community awareness of caring and compassionate care. These behavioral and practice changes in a model approach answered the study's propositions converging at the same time to describe the one phenomenon of the holistic health paradigm, the cultural specific approach.

The revelatory action (Yin, 2014) of aligning the EIM and the Cultural Specific Approach is a purposeful association to draw from the rich heritage of the American Indian and uphold their cultural identity. Data were presented in a methodological progression of three case study units. The case studies were instruments testing the theory of culturally specific components that should presumptively make a difference in the thoughts, intent, and desire to become healthy, even in the case of an overdose before treatment. The cultural specific approach provided a relationship that the Anishinaabe people could relate and subjectively adhere to innate principles that defined their identity. The cases were successful in opioid treatment and more optimistic for opioid patients.

### 5.3 The Care Approach and Relationship Building

The nomothetic study supports the proposition that the Cultural Specific Approach to Health Model contributes to the understanding of relationship care and patient-centeredness. This relationship of patient-centeredness and relationship care contribute to the understanding that community-specific aspects are recognized as best practices in the optimization of health care among adult Anishinaabe reservation residents with chronic

illness and substance use disorder. The five thematic domains that were constant as a result of the case study findings are qualitatively summarized as:

1) Optimization of health care initiatives based on community perspectives, 2) Pharmacist-medical team engagement, (3) pharmacist-led care team delivery processes, (4) evaluation of redesign thinking services, and (5) policies that ensure consistency and quality of care.

## 5.4 Convergence of the Methods and Care Approach and the Nomothetic Span

The cultural specific approach is strengthened with practice management in concordant competency, using convergence analysis. The convergence analysis means to address everything in a holistic way and not separated into individual parts. With the nomothetic approach, the deductive reasoning and logic support this process. The *a priori* status of the Cultural Specific Approach is substantial to addressing a new theoretical model that affects consequential constructs. It changes the philosophical approach and identity factors which usually confound other research or rival theory. As a causal argument, the nomothetic technique answers the questions, "why and how" and the nomothetic span captures the meaning of a construct as established through its network of relationships with other constructs (Strauss and Smith, 2009). In this methodology, the Cultural Specific Approach construct was evinced in the three case study units and were part of the analytic methods, initiating from thought and theory development of the *a priori* Cultural Specific Approach in Case Study One to application of the theory in Case Study Two, and dissemination of results through policy changes and legislation in Case Study 3

(Figure 5). The results of these initiatives reflected in the highest recovery rate of the opioid treatment center, increased re-integration of community membership, increase in partnership with local hospitals and treatment centers, and re-introduction of healthy behavioral changes.

The results of placing the antecedent cultural specific characteristics of community membership were positively revealing and demonstrated that there were possibilities for behavioral change in a short amount of time. The Cultural Specific Approach model positively changed behaviors within a population that demonstrates the highest prevalence for diabetes, the incidence of comorbid illness, and substance use disorder. Utilizing the Cultural Specific Approach model and integrated therapies derived from the pharmacist-led, holistic, patient-centered perspective, the Cultural Specific Approach model radically transformed treatment for patients, and these developments produced the best results within the shortest time for the patients in treatment. The results of the study also confirmed that funding was necessary to provide supportive services for transitional care homes for both males and females and those families with children. With the successes, payers were more likely to fund these initiatives because of the sustainability of the approach.

# CHAPTER 6

# DISCUSSION and CONCLUSIONS

## 6.1 Discussion of Key Findings

Formation of new roles for the pharmacist have expanded professional capacity due to policy-driven initiatives, such as the epidemic of opioid overdose and opioid use disorder. As stakeholders are taking steps toward recovery, clinicians and pharmacists provide professional knowledge of chronic care models for specific communities and minority populations. Key findings in theory framework and adaptation of new questions support the objective of the study.

The objective of this study is to codify the Cultural Specific Approach as *a priori* construct to establish a new framework of healthcare modeling through the relationship of the Anishinaabe peoples' cultural specific construct of *Bimaadiziwin.*

The four propositions of the study are: (1) Why are phenological or traditional practices important to understand with the Cultural Specific Approach? (2) What is the relationship of spiritual and healing practices contributing to Cultural Specific Approach? (3) What role does happiness discriminate in the psychosocial relationship to Cultural Specific Approach? (4) What best defines professional cultural competency for practitioners to enhance patients' perceptions of health and reported outcomes?

The nomothetic study supports the propositions that the Cultural Specific Approach to Health Model contributes to the understanding of relationship care and patient-centeredness. This contributes to the understanding that community-specific aspects are

recognized as best practices in the optimization of health care among adult Anishinaabe reservation residents with chronic illness and substance use disorder.

Five thematic domains that were constant as a result of the case study findings are qualitatively summarized as: 1) Optimization of health care initiatives based on community perspectives, 2) Pharmacist-medical team engagement, (3) pharmacist-led care team delivery processes, (4) Evaluating of redesign thinking services, and (5) policies that ensure consistency and quality of care.

The first area of findings suggests optimization of healthcare can be attributed to understanding the characteristics of the community. This is a strength-based approach to accepting the value and promise of what exists in the community already. Revisiting the four categories (Figure 9), phenological and traditional activities include a myriad of activities that are not all listed, combined with spiritual and healing relationships, including Western Medicine, and the cultural expressions of happiness, bonding, values elucidated in healthcare concerns and training of pharmacists. This combination is a valuable basis for predicting a single case phenomenon of cultural specificity known to the Anishinaabe as Bimaadiziwin.

The second area of findings reveals professional partnerships between the pharmacist and medical team on special assignment, the opioid response team. All case study units expressed the presence of the embedded units (Figure 6) as the initial foundation to develop a responsive approach to chronic illness within the treatment groups. Afterall, the results of the induction in treatment often revealed comorbid states of ill health. This partnership created new engagement opportunities for research and revision of

treatment plans for the patients.

The third area of findings explain the pharmacist-led care team delivery processes that were practice-based in collaboration with the medical doctors. Medication Assisted Therapies and Medication Assisted Recovery were specialty areas that involved the pharmacist to evaluate drug therapies on all levels based on clinical drug tests.

The fourth area of findings is summarized by the new standards of evaluating the redesign thinking services. The redesign thinking protocol is informative but evolves to describe best practices for the pharmacy professional. The pharmacy practice profession has initiated steps to combat the opioid crises and within the results of the case studies, the pharmacist-led team approach had the most effect. The training of the Pharm. D. pharmacist was the catalyst that brought the knowledge of safe use of medication to community members, not just patients. This practice area also provides incentive to explore additional research possibilities based on the enhanced curriculum and professional research competencies (National Organization of State Offices of Rural Health, 2017).

The fifth area of findings promote policies that support consistency and quality of care for clients and patients. The comprehensive nature of the opioid crisis and realization that the nature of addiction involves multifaceted concerns of psychosocial and medical matters for the patient and their families brings the profession of pharmacy closer to expanding or transforming point of care evidence-based policies for community-wide programs and practices (Radel et al., 2018). Pharmacy can advance the use of the science to improve the lives of Native Americans living with substance use disorders and mental illness, as well as their families, by increasing access to the full continuum of medication

services for mental and substance use disorders. Identification of a new approach to national, regional, and local training and technical assistance, the dissemination and adoption of evidence-based practices, and outreach and engagement, the profession of pharmacy, engaged as a community partner, will work to ensure Native Americans understand and have access to a comprehensive continuum of mental and substance use disorder services with least or lowest minimum medication, including high-quality, evidence-based prevention, treatment, and recovery support services (Smeulers, et al., 2015; Hepler and Strand, 1990). Engaging in outreach to clinicians, grantees, patients, and the public community. Hospitals, clinics, and treatment centers were vital in collecting information that was previously not addressed. The clinic medical administrators and clinical pharmacists contributed to analyzing, and disseminating data to inform policies, programs, and practices. Through grant funding, pharmacists as providers enhance the practice and contribution to the promotion of wellness though its strengths in practice areas of medication usage, workforce, and performance data collection, outcomes, evaluation, and quality support efforts to enhance health care and health systems integration. Pharmacists are able to identify safe medication standards and to address mental and substance use disorder-related disparities; to identify what works through tailored precision medication initiatives and this research strengthens and builds the provision of evidence-based behavioral health services for Native Americans. Such performance-based efforts will be conducted by university pharmacy divisions and research partners (TEC, NIH, SAMHSA, NIHB, CDC and the DOJ) along with federal, state, territorial, tribal, and community partners and will directly improve the education impact through delivery of

appropriate medication education services, promote awareness, and will inform the development of policy and programmatic initiatives. Maintaining relevant information and collaborative knowledge at-the-ready are a priority in times of crisis, as now most state and federal organizations and tribal governments experienced when the opioid fatalities arose. This example turned many policies obsolete and new policies with provisions of care had to be written based on the pharmacists' recommendation of therapies.

A union of collaborative professions addressed the preeminent opioid crisis instead of individual medical or behavioral divisions. Establishment of policies and laws that support the availability of mental and substance use disorder services is integral to everyone's health, and the profession of pharmacy will lead efforts to advance the recognition of addiction in its many forms of mental health and as being essential to overall health. In rural communities, such recognition and focus will help to prioritize access to and improve integration of services, support the development of funding mechanisms to support and sustain positive outcomes, and address gaps and disparities in community contract health service delivery areas (CHSDAs). CHSDAs are the foundation to reimbursement in community clinics and hospital service programming, and many programs are affected by the ability to sustain a continuum of funding resource and improve the revenue stream. These findings are relevant for policy development because, in many instances of opioid care, the laws are not yet developed i.e., acute and chronic long-term waivers, consistency of morphine equivalent dosing, therapies of opioid, substance use disorder policies, and policy development for associated social services and administrative decisions within the hospital and clinics.

## 6.2 Usefulness and Implications of Study Findings

Several strategies to strengthen the pharmacists' role in building a treatment program for opioid use disorder involve their recommendations aligned with the specific cultural health initiatives. Table 1. provides harm reduction activities that pharmacists can deliver within the community in response to substance use disorder and bring attention to medication education and medication safety. Presenting with the physicians as a team creates dynamic roles that complement the prevention and surveillance actions to reduce opioid adverse events.

These activities were highly successful and effective in the first case study unit. Dissemination of the opioid plan was pharmacist-led in partnership with the physicians and led to national and federal recognition for the tribal opioid response. The dissemination of the complete response to opioid care was provided upon review with the engagement of local community hospitals and community. Further, the enactment of the policies helped to provide an expanded framework of practice management and accountability with increased integration of pharmacy education, medication management, and evaluation. These policies helped drive a proactive approach to medication pain management and opioid prevention studies research.

Table 2. displays the four propositions that frame the study only. The four propositions are linked to the cultural specific conditions labeled 1) Regional, 2) Beliefs, 3) Norms, and 4) Constants of the data.

Table 2. Linking Data to Propositions: Technique of Understanding the Chain of Command and Embedded Units

| Cultural Specific Approach Condition | Embedded Units | Proposition 1 | Proposition 2 | Proposition 3 | Proposition 4 | Logic Model Explanation |
|---|---|---|---|---|---|---|
| Region | Phenologic & Traditional Activities | Why are phenological or traditional practices important to understand with the Cultural Specific Approach? | | | | Narrative form based on historical and informed collaboration |
| Beliefs | Spiritual & Healing Relationships | Why is the relationship of spiritual and healing practices significant to the contribution to the Cultural Specific Approach? | | | | Narrative form based on collaborative observations and experiential learning |
| Norms | Cultural Expression & Happiness | What role does happiness discriminate in the psychosocial relationship to Cultural Specific Approach? | | | | Narrative form based on survey and informed collaboration |
| Constant | Person Oriented Demographics | What best defines professional cultural competency for practitioners to enhance patient's perceptions of health and reported outcomes? | | | | Redesign thinking based on contextual conditions |
| Cultural Specific Approach | Concordant ethnographic competency | Convergence analysis | | | | *a priori* position versus rival interpretation(s) |
| Original Innovative Theory | Theory-building structures | Causal Analytic Argument to develop ideas for further study | | | | Answers "why and how" |

*Note.* Integration of the logic model, questions (propositions), Cultural Specific Approach constructs termed 'conditions' and embedded units. The theory supporting the *a priori* Cultural Specific Approach maintains a concordant approach for the provider to gain competency with the patient in a respectful manner. Likewise, the strengths-based approach encourages meaningful participation with the patient ensuring better quality outcomes that can be measured and quantified. Thus, building upon all data with the nomothetic approach, theory design thinking becomes a strength and provides robustness in generating better fit models for health innovation.

The Region-specific condition identifies the Midwest area that is occupied by the majority of Anishinaabe tribal members and is best suited for research on Bimaadiziwin,

the operant cultural specific health belief of the Anishinaabe. The Logic model must include narratives based on historical and interviews, informed collaboration.

The Belief specific condition is characterized by Anishinaabe reservations where the Midewewin medicine lodges are located, and belief modalities are practiced. Belief, also, characterizes traditional activities and relationships most relevant to sovereign Anishinaabeg nations. Question 2 identifies the relationship between spiritual and healing practices significant to the Anishinaabeg through the Cultural Specific Approach in healing. The Logic model must include a narrative form with collaborative observations and permission and experiential learning activities.

The Norms specific condition is explained by cultural expressions of happiness and contentment with self-reported Anishinaabe culture. Norms are highly representative of who the Anishinaabe people are and how vital collaborative practices are to readdress questions that support research study at its first phase. Question 3 explains the role happiness has in the life and psychosocial identity of the Anishinaabeg. Logic models are narrative forms based on survey and informed collaborations.

The Constant specific condition is expressed as the person-oriented demographics for the regional Anishinaabe. The result of placing the demographic section here and related to the 4th question is novel. Based on the Cultural Specific Approach, the decision to use the demographic tribal name, regional zip codes, questions about cultural relevancy, thoughts, ways of action and ways of thinking all relate to the identity and individual composition captured in the demographics. The demographics section is a particularly important section that affects the whole survey. Question 4 explains the professional

cultural competency for practitioners that enhance patient's perceptions of health and reported outcomes. The Logic models create a redesign thinking as explained.

Table 3. indicates the presence of the cultural specific health belief, Bimaadiziwin throughout the study and the questions provide the boundary of inquiry. This study is a qualitative design and corresponds (links) to findings from the three case studies. The three case studies are a progression that were evinced throughout the 2017-18 year. The case studies are explanatory, single case phenomenon of the Cultural Specific Approach Model and demonstrate multiple aspects that support the qualitative framework of study propositions 1 – 4.

Table 3. Presence (+) of Cultural Specific Approach Bimaadiziwin Linkage to the Case Studies Units

| Cultural Specific Approach: Anishinaabe Bimaadiziwin | | | | | |
|---|---|---|---|---|---|
| Presence of Activities | Proposition 1 | Proposition 2 | Proposition 3 | Proposition 4 | Preliminary Outcomes§ |
| Case Study Title* | | | | | |
| 1 | + | + | + | + | + |
| 2 | + | + | + | + | + |
| 3 | + | + | + | + | + |

*Note.* *Case Study Titles 1 – 3 are listed below:

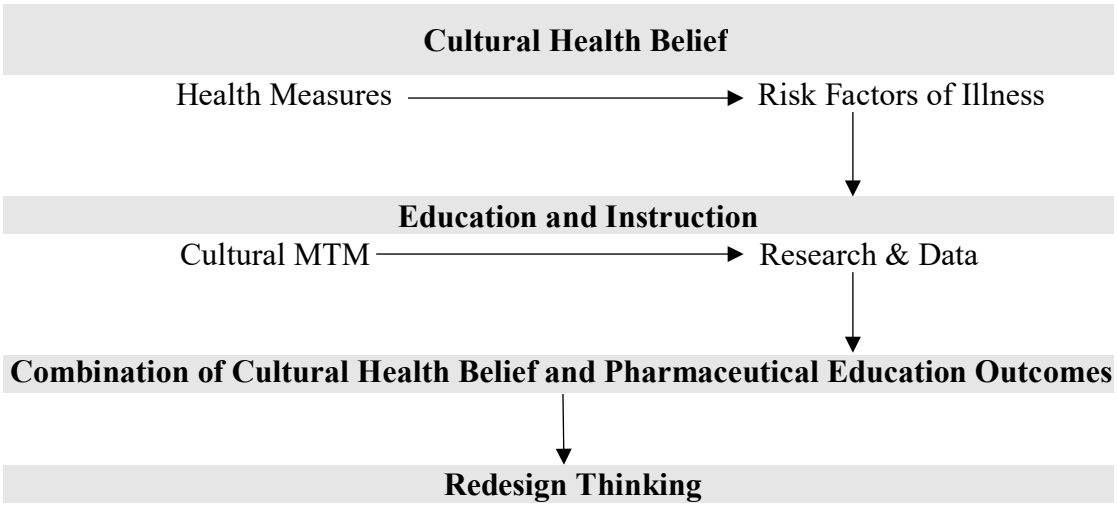
1. *An Informed Methodology Utilizing the Cultural Specific Approach: Supporting the Clinician Response to Crises After Overdose.*
2. *Pharmacist-led Community Engagement and the Role of the Pharmacist to Understand Medication Assisted Recovery with the Cultural Specific Approach.*
3. *Effectiveness of the Cultural Specific Approach to Initiate Policy Changes within Community Clinics.*

§. Evaluation of Research Outcomes and the Cultural Specific Approach Model assessment and evaluation are dependent on longitudinal data and replicability to validate theory

Theoretical results of the Redesign Thinking model (Table 4*)* explain the

comprehensive plan utilizing the Cultural Specific Approach model. The explanation of the redesign thinking model reveals the relationship of the pharmacy professional curriculum to the outcomes.

Table 4. Significance of Redesign Thinking to the Cultural Specific Approach to Health Model




*Note.* The significance of the redesign thinking model launches efficient practice management constructs based on the applicability and logic of the cultural specific approach. The cultural health belief model based on the *a priori* construct affects consequential actions of rival theories and predicts new avenues for further exploration and robust research methods in pharmacy education. This logic model emphasizes revisiting the mission and vision goals within departmental organizational management teams. These models are typically recursive and can then generate the systematic and predictive measurement of outlined goal success. At any point, the system can be measured with benchmarks and milestone achievements for accreditation standards.

Health measures consisting of data end points delineate the risk factors of illness within the community. The cultural health beliefs are protective factors that provide hope

for wellness and happiness, social determinants of health. Better opportunities that inform and educate community members of the prevention of illness are contingent on the degree of integration of the pharmacist and providers in relationship to the community.

The cultural approach to medication therapy management is best attributed to the pharmacist who makes time and purpose of getting to know the patients. These activities may require the pharmacist to spend more hours outside the usual day-to-day activities, but the greater response usually facilitates a successful mediation of prescribed medication adherence.

Positioning the pharmacist integrated within the community offers the researcher opportunities to gather meaningful data and provision to present the findings back to the community. In some areas, the pharmacist only dispensed medication once a week with the rest of the time, the clinical pharmacists were conducting home visits, participating in community forums, 911 calls, medication education, addressing questions procured by the administration of the hospitals and clinics, quality improvements, and reviewing law standards. The pharmacist spent time reviewing quality of care matters for clinic and community hospital patients, supported elderly psychosocial evaluations with subsequent visits to their medication cabinet, medication reconciliation, medication counseling, and nutrition counseling. At scheduled times, the pharmacist met with clients in drug treatment and discussed their goals of therapy, medication assisted treatment and recovery. The pharmacist was able to travel to professional meetings and travel, participate in research initiatives, and revising informational materials for dissemination.

The combination of cultural health belief and pharmaceutical outcomes provide a

healthier environment for the patient and successful treatment of the drug therapy management plan. While this is a simple plan, the idea to promote a pharmacist-led approach to management of medications is a redesign thinking strategy that requires administrative policy change to enact pharmacists as providers (Consuelo et al., 2019). Federal pharmacists already have the provider status and it is very beneficial when utilized.

### 6.3 Strengths and Limitations of the Study

The strengths of the study are drawn as success stories within the conclusions of the three case study units. Additional strengths are replicability of the design to all other communities of people and recognition of the professional provider status and professional capacity of the Pharm. D. trained pharmacists who transformed the environment of the hospital and clinic in many rural communities. Pharmacists have provider status within the IHS and this professional designation is valuable in HPSAs.

The first limitation of the Cultural Specific Approach beyond this study is only intended for the Anishinaabe, so other tribes or communities must develop their specific questions of the characteristics that define them, and this may be different than what is expressed in this work. However, the model is generalizable to all organizations (see Table 4) and can be utilized if so chosen beyond this study, and the mixed methods can justify the outcomes. Since each of those tribes possesses a different health belief distinctive to their belief system then, the Cultural Specific Approach Model is appropriately utilized. Nevertheless, the scope of the study is intended to inform the practitioners, providers, and researchers of the significance of the Cultural Specific Approach Model and its strengths of practical purpose in times of crises.

The second limitation of the study risks error in using sampling methods that may miss qualifying individuals. This sample may not reflect those Anishinaabe people who live off the reservation and possess the same overarching belief system of Bimaadiziwin.

The third limitation of this research is an ecological fallacy that the study outcomes may not reflect what the current membership "thinks" (Angmarlik, Kulchyski, McCaskill and Newhouse 1999; Archuleta, Child, Lomawaima and Heard Museum, 2000). Quite often, standard definitions develop within cultures of people through time, and these definitions may be bound by the period that is being studied. Anthropological studies and ethnographical histories are significant to achieve an informed background knowledge of the culture. In American Indian cultures, this practice procedure is vital to understanding the nature of the spirit of the community represented. If a historical - comparative study is available, the information presents an opportunity to help acquaint the researcher in understanding the cultural specificity of the community and the evolution of norms.

The fourth limitation is noted by the demonstration of the Hawthorne effect that participants may change their behavior upon answering their survey questions differently or in practice, intent on taking their medication differently when in the presence of a provider or someone important to their decision-making scope.

### 6.4 Study Conclusions and Future Research

Specific tribal characteristics are best understood with community-based participatory partnerships that utilize the strengths of the pharmacist for virtually all areas of healthcare. Involving the pharmacist in daily life adjustments improves the health

outcomes for patients and clients, but also, improves the capacity of professional programs for the clinicians. Using the three case studies was only one example that offered professional relief for the burden of alleviating chronic pain control and providing answers to clients who needed to understand the consequences of adverse drug complications. Attending to the opioid crises and addressing chronic diabetes complications were two of the highest health situations that cause the systematic failure of hospital systems (Tupper, 2016) because, for most communities, there is no answer or relief. However, for the first time, the tenets of Bimaadiziwin—love, respect, justice, honesty, bravery, humility, and wisdom—collectively prevailed with the community. Moreover, combined with the knowledge of the medication experts, a team of pharmacists and physicians turned back the meteoric statistics of overdose fatalities to progress another day at a time. In all, working with the pharmacist provider team, thirty initiatives addressed the opioid crises for one community, and the case studies reveal there is still much more that can be accomplished. After reviewing the cases during the study years, contemplating future research possibilities are indeed promising.

Future research possibilities include: chronic disease interventions, prevention of chronic illness, surveillance of disease conditions, health promotion of positive living (Anderson, 2018) and mental health promotion (Ralston, Andrews, and Hope, 2019). Pharmacists can pursue new areas in addiction studies, assets-based approaches to depression and happiness studies, medication adherence, and teaching within hospitals and community clinics. There are many opportunities to champion new provider team building, disseminate and broaden crisis-response curriculum and health policy changes.

Pharmacists can build pharmacy law reviews based on new policies, discovery studies in cancer research (toxicology, unique plant-based experiments); and, initiate capacity building (provider status), that increase workforce that reflects these initiatives.

Given the positive changes in rural health with the Cultural Specific Approach and pharmacist capabilities, it is prudent to understand the nature of communities and utilize the information available through associated surveys (homelessness, feasibility, econometric, census) that aggregate data. There are fewer opportunities to gather native person-level data, but as interoperability finds a place in the rural communities, there is more of a need to not put aside the commitment to get to know a community of people. It is the first response in opening up communication that initiates the partnership of pharmacist, provider, and client.

In summary, the findings of this study validate the premise that communities are defined by their characteristics and capitalizing on those attributes provides a foundation to become healthy. The pharmacy practice philosophy intertwined values defined in the pharmacy profession and a broad caring paradigm that shaped more than just a therapeutic relationship with the community member. This dissertation provides the basis of a cultural specific approach to health for pharmacists when working with tribal, rural and urban communities.

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